May 1, 2006 through December 31, 2007

Contract for Medicaid Services

Between

Health Advantage

and

The Wisconsin Department of Health and Family Services

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CONTRACT FOR SERVICES

Between

Department of Health and Family Services

and

MCO

The Wisconsin Department of Health and Family Services (the Department) and the MCO, an insurer with a certificate of authority to do business in Wisconsin, and an organization which makes available to enrolled participants, in consideration of periodic fixed payments, comprehensive health care services provided by providers selected by the organization and who are employees or partners of the organization or who have entered into a referral or contractual arrangement with the organization, for the purpose of providing and paying for Medicaid contract services to recipients enrolled in the Managed Care Organization (MCO) under the State of Wisconsin Medicaid Plan approved by the Secretary of the United States Department of Health and Human Services pursuant to the provisions of the Social Security Act and for the further specific purpose of promoting coordination and continuity of preventive health services, of care for persons with disabilities receiving community-based services, and of other medical care including prenatal care, emergency care, and HealthCheck services, do herewith agree:

ARTICLE I

I. DEFINITIONS

Terms that are not defined in this Article shall have their primary meaning identified in the Wisconsin Administrative Code (Wis. Adm. Code), Chs. HFS 101-108.

Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to Medicaid, in reimbursement for services that are not medically necessary, or in services that fail to meet professionally recognized standards for health. Abuse also includes client or member practices that result in unnecessary costs to Medicaid.

Action: The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension or termination of a previously authorized service; the denial, in whole or in part, of payment for a service.

Affirmative Action Plan: A written document that details an affirmative action program.

Appeal: A request for review of an action.

Balanced Workforce: An equitable representation of persons with disabilities, minorities and women available for jobs at each job category from the relevant labor market from which the recipient recruits job applicants. (Wisconsin Contract Compliance Law, Chapters 16.765.)

Business Associate: Parties authorized to exchange Electronic Data Interchange (EDI) transactions on the Trading Partner's behalf.

Care Coordination: The integration of all processes in response to a client's needs and strengths to ensure the achievement of desired outcomes and the effectiveness of services (1) provided by a care coordinator for each enrollee, and (2) supervised by individuals with the equivalent training and experience of a person with an R.N. nursing degree and experience with disabled recipients, or a certified social worker with medical background, or a nurse practitioner. Care coordination includes:

Care Plan Development: As defined in this Article and in Article III, F.

Service Coordination: The comprehensive organization of combined medical and social services across the continuum for the greatest benefit to the client and the most efficient use of resources. This includes arranging for service provision in the optimum combination and sequence, monitoring the provision of needed services and incurring an obligation to pay for Medicaid-covered services provided.

Care Evaluation: Tracking the outcome of services and the attainment of care plan objectives. Care or service plans may be adjusted accordingly.

Service Management: Administering the provision of a few basic services. In addition to service authorization, this may include abbreviated planning, coordination and evaluation without formal case management (e.g., the isolated need for a ride or a meal).

Care Management System: Care management includes a comprehensive assessment and care plan, care coordination and case management services. This includes a set of processes that arrange, deliver, monitor and evaluate care, treatment and medical and social services to a person.

Care Plan: Written documentation of decisions made in advance of care provided, based on a comprehensive assessment of a person's needs, preferences and abilities, taking into account how services will be provided. This includes establishing objectives (desired outcomes) with the client and determining the most appropriate types, timing, and supplier(s) of services. This is an ongoing cycle of activity as long as care is being provided

Case Management: The management of complex clinical services needed by MCO enrollees, ensuring appropriate resource utilization and facilitation of positive outcomes. For persons with serious mental illness, case management should be provided by and supervised by persons with mental health expertise.

CESA: Cooperative Educational Service Agencies, which are cooperatives that include multiple school districts that work together for purchasing and other coordinated functions. There are 12 CESAs in Wisconsin.

CFR: Code of Federal Regulations.

Children with Special Health Care Needs: Children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally and who are enrolled in a Children with Special Health Care Needs program operated by a local health department or a local Title V funded Maternal and Child Health Program.

Clean Claim: A truthful, complete and accurate claim. A claim that does not have to be returned for additional information.

Community-Based Health Organizations: Non-profit agencies providing community-based health services. These organizations provide important health care services such as case management for persons with disabilities, HealthCheck screenings, nutritional support, and family planning, targeting such services to high risk populations.

Comprehensive Assessment: A detailed assessment of the nature and cause of a person's specific conditions and needs as well as personal resources and abilities. This is generally performed by an individual or a team of specialists and may involve family, friends, peers or other significant people. In some instances, the assessment may be done in conjunction with care planning. A face-to face interview is the preferred method of assessment and should be done if possible.

Continuing Care Provider: A provider who has an agreement with the Medicaid agency to provide (as stated in 42 CFR 441.60(a)):

A. Reports that the Department may reasonably require; and

B. The following services to eligible HealthCheck recipients formally enrolled with the provider as enumerated in 42 CFR 441.60(a)(1)-(5):

   1. Screening, diagnosis, treatment, and referrals for follow-up services.

   2. Maintenance of the recipient's consolidated health history, including information received from other providers.

   3. Physician's services as needed by the recipient for acute, episodic or chronic illnesses or conditions.

   4. Provision or referral for dental services.

   5. Transportation and scheduling assistance.

Contract: The agreement executed between the MCO and the Department to accomplish the duties and functions, in accordance with the rules and arrangements specified in this document.

Contract Services: Services that the MCO is required to provide under this contract.

Contractor: The MCO awarded the contract to provide capitated managed care in accordance with this contract.

Covered Entity: A health plan, a health care clearinghouse, a health care provider or MCO that transmits any health information in electronic form in connection with a transaction covered by 45 CFR Parts 160 and 162.

Cultural Competency: A set of congruent behaviors, attitudes, practices and policies that are formed within an agency and among professionals that enable the system, agency, and professionals to work respectfully, effectively and responsibly in diverse situations. Essential elements of cultural competence include understanding diversity issues at work, understanding the dynamic of difference, institutionalizing cultural knowledge, and adapting to and encouraging organizational diversity.

Department: The Wisconsin Department of Health and Family Services (DHFS).

Department Values: The Department's shared values include:

- An emphasis on a family centered approach.
- Enrollee involvement throughout the process.
- Building resources on natural and community supports.
- A strength based approach.
- Providing unconditional care.
- Collaborating across systems.
- Using a team approach across agencies.
- Being gender, age and culturally responsive.
- Promoting a self-sufficiency focus on education and employment where appropriate.
- A belief in growth, learning and recovery.
- Being oriented to outcomes.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

A. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

B. Serious impairment of bodily functions; or

C. Serious dysfunction of any bodily organ or part; or

D. With respect to a pregnant woman who is in active labor:

1. Where there is inadequate time to effect a safe transfer to another hospital before delivery; or

2. Where transfer may pose a threat to the health or safety of the woman or the unborn child.

E. A psychiatric emergency involving a significant risk of serious harm to oneself or others.

F. A substance abuse emergency exists if there is significant risk of serious harm to an enrollee or others, or there is likelihood of return to drug abuse without immediate treatment.

G. Emergency dental care is defined as an immediate service needed to relieve the patient from pain, an acute infection, swelling, trismus, fever, or trauma. In all emergency situations, the MCO must document in the recipient's dental records the nature of the emergency.

Emergency Services: Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under this title, and needed to evaluate or stabilize an emergency medical condition.

Encounter: For the purposes of this contract, the term "encounter" shall include the following:

A. A service or item provided to a patient through the health care system. Examples include but are not limited to:

1. Office visits
2. Surgical procedures
3. Radiology, including professional and/or technical components
4. Prescribed drugs
5. Durable medical equipment
6. Emergency transportation to a hospital
7. Institutional stays (inpatient hospital, rehabilitation stays)
8. HealthCheck screens
9. Community Support Programs
10. Case Management

B. A service or item not directly provided by the MCO, but for which the MCO is financially responsible. An example would include an emergency service provided by an out-of-network provider or facility.

C. A service or item not directly provided by the MCO, and one for which no claim is submitted but for which the MCO may supplement its encounter data set. Such services might include HealthCheck screens for which no claims have been received and if no claim is received, the MCO's medical chart. Examples of services or items the MCO may include are:

1. HealthCheck services
2. Immunizations

The terms "services" or "items" as used above include those services and items not covered by the Wisconsin Medicaid program, but which the MCO chooses to provide as part of its Medicaid managed care product. Examples include educational services, certain over-the-counter drugs, and delivered meals.

Encounter Record: An electronically formatted list of encounter data elements per encounter as specified in the Wisconsin Medicaid MCO Encounter Data User Manual. An encounter record may be prepared from a single detail line from a claim such as the CMS 1500, UB-92, or ASCX12N 837.

Enrollee, Member, **Participant, Consumer:** A Medicaid recipient who has been certified by the State as eligible to enroll under this contract, and whose name appears on the MCO Enrollment Reports, which the Department will transmit to the MCO every month in accordance with an established notification schedule.

Enrollment Area: The geographic area (Dane County) within which recipients must reside in order to enroll, on an Voluntary basis, in the MCO under this contract.

Experimental Surgery and Procedures: Experimental services that meet the definition of HFS 107.035(1) and (2) Wis. Adm. Code as determined by the Department.

Formally Enrolled with a Continuing Care Provider (as cited in 42 CFR 441.60(d)): A recipient (or recipient's guardian) agrees to use one continuing care provider as the regular source of a described set of services for a stated period of time.

Fraud: An intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in some unauthorized benefit to him/herself, itself or to some other person or entity. It includes any act that constitutes fraud under applicable federal or state law.

Gatekeeper: Any entity that performs a management services contract, a behavioral health science IPA, or a dental IPA, and not to individual physicians acting as a gatekeeper to primary care services.

Grievance: An expression of dissatisfaction about any matter other than an action. The term is also used to refer to the overall system that includes grievances and appeals handled by the MCO. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights.

HHS: Health and Human Services.

HHS Transaction Standard Regulation: The 45 CFR, Parts 160 and 162.

HIPAA: The Health Insurance Portability and Accountability Act of 1996, federal legislation that is designed to improve the portability and continuity of health insurance.

Individually Identifiable Health Information (IIHI): Patient demographic information, claim data, insurance information, diagnosis information, and any other care or payment for health care and that identifies the individual (or there is reasonable reason to believe could identify the individual).

Information: Any "health information" provided and/or made available by the Department to a Trading Partner, and has the same meaning as the term "health information" as defined by 45 CFR Part 160.102.

IPA: Independent Physician Association.

Local Health Department (LHD): An agency of local government established according to Chapter 251, Wis. Stats. LHDs have statutory obligations to perform certain core functions, which include assessment, assurance, and policy development, for the purpose of protecting and promoting the health of their communities.

MCO: The managed care organization or its parent corporation, with a certificate of authority to do business in Wisconsin that is obligated under this contract.

MCO Encounter Technical Workgroup: A workgroup composed of MCO technical staff (and contract administrators, claims processing, eligibility, and other MCO technical staff as necessary), department staff from the Division of Health Care Financing, and staff from the Department's fiscal agent contractor.

Medicaid: The Wisconsin Medicaid program operated by the Wisconsin DHFS under Title XIX of the Federal Social Security Act, Ch. 49, Wis. Stats. and related state and federal rules and regulations. This will be the term used consistently in this contract.

Medical Status Code: The two-digit (alphanumeric) code that the Department uses in its computer system to define the type of Medicaid eligibility a recipient has. The code identifies the basis of eligibility, whether cash assistance is being provided, and other aspects of Medicaid. The medical status code is listed on the MCO Enrollment Reports.

Medically Necessary: A medical service that meets the definition of HFS 101.03(96m), Wis. Adm. Code.

Member-Centered Care: Member-centered care is care that explicitly considers the member's perspective and point of view. For example, a member-centered care plan will include treatment goals and expected outcomes identified by the member, often expressed in the member's own words. A member-centered needs assessment includes the needs expressed by the member whether or not those needs fit neatly into medical or health nomenclatures. Member-centered care actively engages the patient throughout the care process.

PCP: Primary Care Provider including, but not limited to FQHCs, RHCs, tribal health centers and physicians, nurse practitioners, nurse midwives, physician assistants and physician clinics with specialties in general practice, family practice, internal medicine, obstetrics, gynecology, and pediatrics.

Post Stabilization Care Services: Medically necessary non-emergency services furnished to an enrollee after he or she is stabilized following an emergency medical condition.

Provider: A person who has been certified by the Department to provide health care services to recipients and to be reimbursed by Medicaid for those services.

Public Institution: An institution that is the responsibility of a governmental unit or which has a governmental unit exercising administrative control as defined by federal regulations including but not limited to prisons and jails.

Recipient: Any individual entitled to benefits under Title XIX of the Social Security Act, and under the Medicaid State Plan as defined in Chapter 49, Wis. Stats.

Recovery: Recovery refers to an approach to care that is consistent with HFS 36.03(23) and which has as its goal a decrease in dysfunctional symptoms and an increase in maintaining the person's highest level of health, wellness stability, self-determination and self-sufficiency. Care that is consistent with recovery emphasizes the enrollee's strengths, recognizes their ability to cope under difficult circumstances, and actively engages as partners in the provision of health care (see member-centered care).

Risk: The possibility of monetary loss or gain by the MCO resulting from service costs exceeding or being less than payments made to it by the Department.

Secretary: The Secretary of HHS and any other officer or employee of the Department of HHS to whom the authority has been delegated.

Service Area: An area of the State of Wisconsin where the MCO has agreed to provide Medicaid services to Medicaid enrollees. The MCO will indicate whether they will provide chiropractic services by service area. A service area may be a county, a number of counties, or the entire state.

State: The State of Wisconsin.

Subcontract: Any written agreement between the MCO and another party to fulfill the requirements of this contract. However, such term does not include insurance purchased by the MCO to limit its loss with respect to an individual enrollee, provided the MCO assumes some portion of the underwriting risk for providing health care services to that enrollee.

Trading Partner: A provider or a MCO that transmits any health information in electronic form in connection with a transaction covered by 45 CFR Parts 160 and 162, or a business associate authorized to submit health information on the Trading Partner's behalf.

Transaction: The exchange of information between two (2) parties to carry out financial or administrative activities related to health care as defined by 45 CFR Part 160.103.

Wisconsin Tribal Health Directors Association (WTHDA): The coalition of all Wisconsin American Indian tribal health departments.

Terms that are not defined above shall have their primary meaning identified in the Wis. Adm. Code, Chapters HFS 101-108.

ARTICLE II

II. DELEGATIONS OF AUTHORITY

The MCO shall oversee and remain accountable for any functions and responsibilities that it delegates to any subcontractor. For all major or minor delegation of function or authority:

A. There shall be a written agreement that specifies the delegated activities and reporting responsibilities of the subcontractor and provides for revocation of the delegation or imposition of other sanctions if the subcontractor's performance is inadequate.

B. Before any delegation, the MCO shall evaluate the prospective subcontractor's ability to perform the activities to be delegated.

C. The MCO shall monitor the subcontractor's performance on an ongoing basis and subject the subcontractor to a formal review at least once a year.

D. If the MCO identifies deficiencies or areas for improvement, the MCO and the subcontractor shall take corrective action.

E. If the MCO delegates selection of providers to another entity, the MCO retains the right to approve, suspend, or terminate any provider selected by that entity.

ARTICLE III

III. FUNCTIONS AND DUTIES OF THE MCO

In consideration of the functions and duties of the Department contained in this contract the MCO shall:

A. Statutory Requirement

Retain at all times during the period of this contract a valid Certificate of Authority issued by the State of Wisconsin Office of the Commissioner of Insurance.

B. General Provision of Contract Services

1. Promptly provide or arrange for the provision of all services required under s. 49.46(2), Wis. Stats., and HFS 107 Wis. Adm. Code; as further clarified in all Wisconsin Medicaid Program Provider Handbooks and Updates, and MCO Contract Interpretation Bulletins (CIBs) and as otherwise specified in this contract, except:

    a. Common Carrier Transportation, except as provided below.
    b. Prenatal Care Coordination (PNCC), except MCO must sign a Memorandum of Understanding as defined in Addendum V.
    c. School-Based Services (SBS), except MCO must use its best efforts to sign a Memorandum of Understanding as defined in Addendum VII.
    d. Tuberculosis-related Services.
    e. Crisis Intervention Benefits.
    f. Day Treatment for Mental Health and Substance Abuse.
    g. Comprehensive Community Services (CCS).

2. The MCO is required to arrange for transportation for HealthCheck visits. When authorized by the Department, the MCO may provide non-emergency transportation by common carrier or private motor vehicle for HealthCheck visits and be reimbursed by the County.

    The MCO may negotiate arrangements with the local county Department of Health and Social Services for common carrier or private vehicle transportation for MCO services in general and not just for HealthCheck visits. The Department will make a list of county transportation contacts available to MCO upon request.

3. Chiropractic Services – The MCO must cover chiropractic services, or in the alternative, enters into a subcontract for chiropractic services with the state. State law mandates coverage.

4. The covered services under this contract must include the Medicaid funded services under Community Support Programs and/or Targeted Case Management. For terms on rate development, risk adjustment and funding for persons receiving Community Support Program (CSP) or Targeted Case Management (TCM) Services, see Addendum XII.

5. The MCO, when appropriate, must refer to or coordinate with other needed services that are not Medicaid covered services

6. Medical Status Code Changes – Remain liable for provision of care for that period for which capitation payment has been made in cases where medical status code changes occur subsequent to capitation payment.

7. Non-Affiliated Providers – Be liable, where emergencies and MCO referrals to out-of-area or non-affiliated providers occur, for payment only to the extent that Medicaid pays, including Medicare deductibles, or would pay, its fee-for-service (FFS) providers for services to the enrolled population. In no case will the MCO be requested to pay more than billed charges. This condition does not apply to:

   a. Cases where prior payment arrangements were established; and
   b. Specific subcontract agreements.

8. Changes To Medicaid-Covered Services – Changes to Medicaid-covered services mandated by federal or state law subsequent to the signing of this contract will not affect the contract services for the term of this contract, unless agreed to by mutual consent; or the change is necessary to continue to receive federal funds or due to action of a court of law.

   The Department may incorporate any change in covered services mandated by federal or state law into the contract effective the date the law goes into effect, if it adjusts the capitation rate accordingly. The Department will give the MCO at least 30 days notice before the intended effective date of any such change that reflect service increases. The MCO may elect to accept or reject the service increases for the remainder of that contract year.

   The Department will give the MCO 60 days notice of any such change that reflects service decreases, with a right of the MCO to dispute the amount of the decrease within that 60 days. The MCO has the right to accept or reject service decreases for the remainder of the contract year. The date of implementation of the change in coverage will coincide with the effective date of the increased or decreased funding. This section does not limit the Department's ability to modify the Medicaid/MCO contract for changes in the state budget.

9. Payment to Providers for Contract Services – Be responsible for payment of all contract services provided to all Medicaid recipients listed as ADDs

or CONTINUEs on either the Initial or Final Enrollment Reports generated for the month of coverage. Additionally, the MCO agrees to provide, or authorize provision of, services to all Medicaid enrollees with valid Forward cards indicating MCO enrollment without regard to disputes about enrollment status and without regard to any other identification requirements. Any discrepancies between the cards and the reports will be reported to the Department for resolution. The MCO shall continue to provide and authorize provision of all contract services until the discrepancy is resolved. This includes recipients who were PENDING on the Initial Report and held a valid Forward card indicating MCO enrollment, but did not appear as a CONTINUE on the Final Report.

10. Transplants – As a general principle, Wisconsin Medicaid does not pay for items that it determines to be experimental in nature:

    a. Medicaid covers cornea and kidney transplants. These services are no longer considered experimental. Therefore, the MCO must cover these services.

    b. MCO is not required to cover procedures that are approved only at particular institutions, including bone marrow transplants, liver, heart, heart-lung, lung, and pancreas transplants. There are no funds in the FFS experience data (and thus in the MCO capitation rates) for these services.

    Enrollees who have had one (1) or more transplant surgeries referenced in 9, b, will be permanently exempted from MCO enrollment. See Article VII, C, 4, i.

11. Dental Services – The MCO is responsible for Medicaid-covered dental services.

    a. All Medicaid-covered dental services as required under HFS 107.07, provider handbooks bulletins and periodic updates.

    b. Diagnostic, preventive, and medically necessary follow-up care to treat the dental disease, illness, injury or disability of enrollees while they are enrolled in the MCO, except as required in Subsection c.

    c. Completion of orthodontic or prosthodontic treatment begun while an enrollee was enrolled in the MCO if the enrollee became ineligible or disenrolled from the MCO, no matter how long the treatment takes. The MCO will not be required to complete orthodontic or prosthodontic treatment on an enrollee who has begun treatment as a FFS recipient and who subsequently was enrolled in an MCO. [Refer to the chart following this page for

specific details on the completion of orthodontic or prosthodontic treatment in these situations.]

d. The MCO must submit quarterly progress reports to the Department documenting the outcomes or current status of activities intended to increase utilization. These reports are due 15 days after the end of each calendar quarter.

Responsibility for Payment of Orthodontic and Prosthodontic Treatment an Enrollment Status Change Occurs During the Course of Treatment

Person converts from one status to another	Who pays for completion of orthodontic and prosthodontic treatment* where there is an enrollment status change?		
	First MCO	Second MCO	FFS
1. FFS to the MCO covering dental.		N/A	X
2a. MCO covering dental to the MCO not covering dental and the person's residence remains within 50 miles of the person's residence when in the first MCO.	X		
2b. MCO covering dental to the MCO not covering dental and the person's residence is at least 50 miles away from the person's residence when in the first MCO.			X
3a. MCO covering dental to the same or another MCO covering dental and the person's residence remains within 50 miles of the person's residence when in the first MCO.	X		
3b. MCO covering dental to the same or another MCO covering dental and the person's residence is at least 50 miles away from the person's residence when in the first MCO.			X
4. MCO with dental coverage to FFS because:	X		
a. Move out of the MCO service area, but the person's residence remains within 50 miles of the person's residence when in the MCO.		N/A	
b. Move out of the MCO service area, but the person's residence is at least 50 miles away from the person's residence when in the MCO.		N/A	X
c. Person voluntarily disenrolls from MCO.		N/A	X
d. Medical status change to ineligible MCO code, but the person's residence remains within 50 miles of the person's residence when in the MCO.	X	N/A	
e. Medical status change to ineligible MCO code, but the person's residence is at least 50 miles away from the person's residence when in the MCO.		N/A	X
5a. MCO with dental to ineligible for Medicaid, and the person's residence remains within 50 miles of the person's residence when in the MCO.	X	N/A	
5b. MCO with dental to ineligible for Medicaid, and the person's residence is at least 50 miles away from the person's residence when in the MCO.		N/A	X
6. MCO without dental to ineligible for Medicaid.		N/A	X

12. Health Professional Shortage Area (HPSA) – The following provision refers to payments made by the MCO. MCO covered primary care services and emergency care provided to a recipient living in a HPSA or by a provider practicing in a HPSA must be paid at an enhanced rate of 20% above the rate the MCO would otherwise pay for those services.

* Medicaid only covers orthodontic and prosthodontic treatment for those under 21 as a result of a HealthCheck referral (HFS 107.07(3)).

Primary care providers are defined as nurse practitioners, nurse midwives, physician assistants, and physicians who are Medicaid certified with specialties of general practice, OB-GYN, family practice, internal medicine, or pediatrics. Specified MCO-covered obstetric or gynecological services (see the Wisconsin Medicaid Physician Provider Handbook) provided to a recipient living in a HPSA or by a provider practicing in a HPSA must be paid at an enhanced rate of 25% above the rate the MCO would otherwise pay providers in HPSAs for those services.

However, this does not require the MCO to pay more than the enhanced Medicaid FFS rate or the actual amount billed for these services. The MCO shall ensure that the monies for HPSA payments are paid to the physicians and are not used to supplant funds that previously were used for payment to the physicians. The Department will supply a list of the services affected by this provision, the maximum FFS rates, and HPSAs. The MCO must develop written policies and procedures to ensure compliance with this provision. These policies must be available for review by the Department, upon request.

13. HealthCheck

    a. MCO Responsibilities:

        1) Provide HealthCheck services as a continuing care provider as defined in this contract and according to policies and procedures in the Wisconsin Medicaid HealthCheck Provider Handbook related to covered services.

        2) Provide HealthCheck screens upon request. If an enrollee, parent or guardian of an enrollee requests a HealthCheck screen, MCO shall provide such screen within 60 days, if a screen is due according to the periodicity schedule. If the screen is not due within 60 days, then the MCO shall schedule the appointment in accordance with the periodicity schedule.

        3) Provide HealthCheck screens at a rate equal to or greater than 80% of the expected number of screens. The rate of HealthCheck screens will be determined by the calculation in the HealthCheck Worksheet. The MCO may complete the worksheet on its own, periodically, as a means to monitor its HealthCheck screening performance.

    HealthCheck data provided by the MCO must agree with its medical record documentation. For the purpose of the HealthCheck recoupment process the Department will not include any additional HealthCheck encounter records that are received after January 16, 2008, for the year under consideration. (Please

note: This marks the end of the 12½ month period of time from the end of the years under consideration. For example, the cut-off date will be January 16, 2008, for dates of service in 2006.)

b. Department Responsibilities:

The Department will provide quarterly reports to inform the MCO of their progress in meeting the HealthCheck requirements. If the MCO provides fewer screens in the contract year than 80%, the Department will:

1) Recoup the funds provided to the MCO for the provision of the remaining screens. The following formula will be used:

(0.80 x A - B) x (C - D), where:

A = Expected number of screens (Line 6 of HealthCheck Worksheet).

B = Number of screens paid in the contract year as reported in the MCO' Encounter Data Set as of January 16, 2007. (The end of the 12½ month period following the year under consideration.)

C = FFS maximum allowable fee (Line 11 of the HealthCheck Worksheet). The FFS maximum allowable fee is the average maximum fee for the year. For example, if the maximum allowable fee for HealthCheck is $50 from January through June, and $52 from July through December in one calendar year, then the average maximum allowable fee for the year is $51.

D = MCO discount, if applicable.

2) Determine the amount of the MCO's HealthCheck recoupment.

3) Determine the actual number of screens completed, for the recoupment calculation (Line 8 of the Worksheet), by using the number of screens reported in the MCO's Encounter Database for calendar year 2005. The Department will identify and retrieve the HealthCheck screening data from the Encounter Database.

When assigning HealthCheck screens to an age category, the Department will use the member's age on the first day of the month in which the screening occurred.

4) Determine the number of eligible months and unduplicated enrollees (Lines 1 and 2 of the Worksheet) per MCO per year, for the HealthCheck recoupment calculation, by using the Medicaid Management Information System Recipient Eligibility File according to the specifications contained in this contract.

When calculating member months for each age category, the Department will use the member's age on the first day of the month.

5) Inform the MCO in writing of its preliminary analysis of the HealthCheck data and allow the MCO 30 business days to review and respond to the calculations. If the MCO responds within 30 business days, the Department will review the MCO's concerns and notify the MCO of its final decision. If the MCO does not respond within 30 business days, the Department will send a "Notice of Intent to Recover" letter 40 days after the initial letter.

c. HealthCheck Redesign Project

The Department is analyzing options for replacing the MCO HealthCheck utilization monitoring recoupment process with a performance improvement incentive program. The Department and MCO will work closely on the HealthCheck redesign project. If the new system requires any changes to the contract, the Department will initiate an amendment to incorporate the changes.

14. Provision of Physician Services to SSI/SSI-Related Medicaid Enrollees – The MCO must adequately fund physician services provided to its SSI/SSI-related Medicaid enrollees so that they are paid at rates sufficient to ensure that provider participation and services are as available to the Medicaid population as to the general population in the MCO service area(s).

15. Medical Necessity – The actual provision of any service is subject to the professional judgment of the MCO providers as to the medical necessity of the service, except that the MCO must provide assessment and evaluation services ordered by a court. Decisions to provide or not to provide or authorize medical services shall be based solely on medical necessity and appropriateness as defined in HFS 101.03(96m). Disputes between the MCO and enrollees about medical necessity can be appealed through an MCO grievance system ultimately to the Department for a binding determination; the Department's determinations will be based on whether Medicaid would have covered that service on a FFS basis (except for certain experimental procedures discussed above). Alternatively,

disputes between the MCO and enrollees about medical necessity can be appealed directly to the Department.

MCO is not restricted to providing Wisconsin Medicaid-covered services. Sometimes, providers find that other treatment methods may be more appropriate than Medicaid-covered services, or result in better outcomes.

None of the provisions of this contract that are applicable to Wisconsin Medicaid-covered services apply to other services that an MCO may choose to provide, except that abortions, hysterectomies and sterilizations must comply with 42 CFR 441 Subpart E and 42 CFR 441 Subpart F.

For services not covered under Medicaid, the MCO must have written policies to ensure things such as safety, provider and employee qualifications (e.g., use of a state certified provider or a provider accredited by a national organization), description of services and intent, and availability for review/audit.

If a service provided is an alternative or replacement to a Wisconsin Medicaid-covered service, then the MCO or MCO provider is not allowed to bill the enrollee for the service.

16. Billing an Enrollee – MCO and its providers and subcontractors shall not bill a Medicaid enrollee for medically necessary services covered under the Medicaid/MCO contract and provided during the enrollee's period of MCO enrollment. MCO and its providers and subcontractors shall not bill a Medicaid enrollee for co-payments and/or premiums for medically necessary services covered under the Medicaid/MCO contract and provided during the enrollee's period of MCO enrollment. Any provider who knowingly and willfully bills an enrollee for a Medicaid-covered service shall be guilty of a felony and upon conviction shall be fined, imprisoned, or both, as defined in Section 1128B.(d)(1) [42 U.S.C. 1320a-7b] of the Social Security Act. This provision shall continue to be in effect even if the MCO becomes insolvent.

    However, if an enrollee agrees in advance in writing to pay for a non-Medicaid-covered service, then the MCO, MCO provider, or MCO subcontractor may bill the enrollee. The standard release form signed by the enrollee at the time of services does not relieve the MCO and its providers and subcontractors from the prohibition against billing a Medicaid enrollee in the absence of a knowing assumption of liability for a non-Medicaid-covered service. The form or other type of acknowledgment relevant to Medicaid enrollee liability must specifically state the admissions, services, or procedures that are not covered by Medicaid.

17. Immunizations – The MCO must share enrollee immunization status with LHDs and other non-profit HealthCheck providers upon request of those

providers without the necessity of enrollee authorization. The Department also requires that local heath departments and other non-profit HealthCheck providers share equivalent information with the MCO upon request. This provision is made to ensure proper coordination of immunization services and to prevent duplication of services.

The MCO must have a signed user agreement with the Wisconsin Immunization Registry (WIR) or must demonstrate that its major providers have signed WIR user agreements.

18. Physician Services – Services required under s. 49.46(2), Wis. Stats., and HFS 107, Wis. Adm. Code, include (without limitation due to enumeration) private duty nursing services, nurse-midwife services, and independent nurse practitioner services; physician services, including primary care services, are not only services performed by physicians, but services under the direct, on-premises supervision of a physician performed by other providers such as physician assistants and nurses of various levels of certification.

19. Provision of Family Planning Services and Confidentiality of Family Planning Information The MCO must give enrollees the opportunity to have a different provider than the enrollee's primary care provider for the provision of family planning services. This provider does not replace the primary care provider chosen by or assigned to the enrollee for the enrollee's other services. The enrollee may choose to receive family planning services at any Medicaid certified family planning clinic even if not in the MCO's network. Family planning services provided at Medicaid certified family planning clinics are paid FFS for MCO enrollees except for pharmacy items ordered by the family planning provider. The MCO is liable for the cost of the prescribed pharmacy items that are filled by an MCO network provider. All information and medical records relating to family planning shall be kept confidential including those of a minor.

C. MENTAL HEALTH/SUBSTANCE ABUSE REQUIREMENTS/COORDINATION OF SERVICES WITH COMMUNITY AGENCIES

MCO must provide Wisconsin Medicaid-covered services, but MCO is not restricted to providing only those services. MCO may find that other treatment modalities are more appropriate and may result in better outcomes than traditional Medicaid-covered services. Whether the service provided is a Medicaid-covered service or an alternative or replacement to a Wisconsin Medicaid-covered service, the MCO or MCO provider is not allowed to bill the enrollee for the service.

1. Conditions on Coverage of Mental Health/Substance Abuse Treatment – On the effective date of this contract the MCO must, in compliance with the provision of s. 632.89 Wis. Stats:

a. Be certified according to HFS 105.21, 105.22, 105.23 to provide mental health and/or substance abuse services; or

b. Have contracted with facilities and/or providers according to HFS 105.21, 105.22, 105.23 and/or 105.255 to provide mental health and/or substance abuse services.

Regardless of whether (a) or (b) above is chosen, such treatment facilities and/or providers must provide transitional treatment arrangements in addition to other outpatient mental health and/or substance abuse services.

Department decisions to waive the requirement to cover these services shall be based solely on whether there is a certified provider that is geographically or culturally accessible to enrollees, and whether the use of psychiatrists or psychologists alone improves either the quality or the cost-effectiveness of care.

In compliance with said provisions, the MCO shall further guarantee all enrolled Medicaid enrollees access to all medically necessary outpatient mental health/substance abuse treatment. The MCO shall not place a monetary limit or limit on the number of hours of outpatient treatment that it will provide or reimburse where it has been determined that treatment for mental illness and/or substance abuse is medically necessary. The MCO shall not establish any monetary limit or limit on the number of days of inpatient hospital treatment where it has been determined that this treatment is medically necessary.

2. Mental Health/Substance Abuse Assessment Requirements

The MCO must assure that authorization for mental health/substance abuse treatment to its enrollees is governed by the findings of an assessment performed promptly by the MCO upon request of a client or referral from a primary care provider or physician in the MCO's network. Such assessments shall be conducted by qualified staff in certified programs, who are experienced in mental health/substance abuse. All denials of service and the selection of particular modalities of service shall be governed by the findings of this assessment, the effectiveness of the proposed therapy for the condition, and the medical necessity of treatment. The lack of motivation of an enrollee to participate in treatment shall not be considered a factor in determining medical necessity and may not be used as a rationale for withholding or limiting treatment of a client/enrollee. The MCO will use Wisconsin Uniform Placement Criteria (WI-UPC) or placement criteria developed by the American Society of Addiction Medicine (ASAM) as mandated for substance abuse care providers in HFS 75. The MCO may, but is not required to, provide care options included in the placement criteria that are not covered services of FFS Medicaid.

The MCO shall involve and engage the enrollee in the process used to select a provider and treatment option. The purpose of the participation is to get a good match between the enrollee's condition, cultural preference, medical needs, and the provider who will seek to meet these needs. This section does not require the MCO to use providers who are not qualified to treat the individual enrollee or who are not contracted providers.

3. Court-Related Substance Abuse Services

The MCO is liable for the cost of providing medically necessary substance abuse treatment, as long as the treatment occurs in an MCO-approved facility or by an MCO-approved provider prescribed in the subject's Driver Safety Plan, pursuant to Chapter 343, Wis. Stats., and HFS 62 of the Wis. Adm. Code. The medical necessity of services specified in this Driver Safety Plan is assumed to be established, and the MCO shall provide those services unless the assessment agency agrees to amend the enrollee's Driver Safety Plan. This is not meant to require MCO coverage of substance abuse educational programs, or the initial assessment used to develop the Driver Safety Plan. Necessary MCO referrals or treatment authorizations must be furnished promptly. A request for referral or authorization for treatment will be considered granted if the MCO does not act upon the request within five (5) days after receipt of a written request. This approval will continue until such time as the MCO otherwise responds in writing. All referrals or authorizations will be retroactive to the date of the request.

4. Crisis Intervention Benefit

The MCO must assign a medical representative to interface with the designees of crisis intervention agencies certified under HFS 34 Wis. Adm. Code that provide services within the MCO service area. The MCO must work with the certified crisis intervention agency to coordinate the transition from crisis intervention care to ongoing Medicaid covered mental health and substance abuse care within the MCO's network, or other care authorized by the MCO. The MCO is not responsible for payment for services provided to their enrollees by certified crisis intervention agencies. Those services are to be billed directly to Medicaid FFS. The MCO is responsible to provide billing information to crisis intervention agency. In addition, the MCO is not required to pay for services directed by the certified crisis intervention agency outside the MCO network, unless the MCO has authorized the services.

5. Court-Related Mental Health Services

The MCO is liable for the cost of all mental health/substance abuse treatment, including stipulated and involuntary commitment, provided by non-MCO providers to MCO enrollees where the time required to obtain such treatment at the MCO's facilities, or the facilities of a provider with which the MCO has arrangements, would have risked permanent damage to the enrollee's health or safety, or the health or safety of others. The court ordered mental health/substance abuse treatment must be in coordination with the responsible legal authority for Chapter 51/55 proceedings. The extent of the MCO's liability for appropriate emergency treatment shall be the current Medicaid FFS rate for such treatment.

a. Care provided in the first three (3) business days (72 hours), plus any intervening weekend days and/or holidays, is deemed emergency care and medically necessary and the MCO is responsible.

b. The MCO is responsible for payment of additional care, beyond the initial 72 hours, only if notified of the emergency treatment within the 72 hours and given the opportunity to provide such care. The opportunity for the MCO to provide care to an enrollee admitted to a non-MCO facility is accomplished if the county or treating facility notifies and advises the MCO of the admission within 72 hours, excluding weekends and/or holidays. The MCO may provide an alternative treatment plan for the county to submit at the probable cause hearing. The MCO must submit the name of an in-plan facility willing to treat the enrollee if the court rejects the alternative treatment plan and the court orders the enrollee to receive an inpatient evaluation.

c. If the county attempts to notify the person identified as the primary contact by the MCO to receive authorization for care, and does not succeed in reaching the MCO within 72 hours of admission excluding weekends and holidays, the MCO is responsible for court-ordered care beyond the initial 72 hours even if provided by a non-MCO provider. The county must document the attempts to notify with dates, times, names and numbers attempted to contact, and outcomes.

d. The MCO is financially liable for the enrollee's court ordered assessment and/or treatment when the MCO enrollee is defending him/herself against a mental illness or substance abuse commitment:

1) If services are provided in the MCO facility; or

2) If the MCO approves provision in a non-contracted facility; or

3) If the MCO was given the opportunity but failed to provide the county with the name of an inpatient facility and, as a result, the enrollee is sent for court ordered evaluation to an out-of-plan provider; or

4) If the MCO gives the county the name of an in-plan facility and the facility refuses to accept the enrollee.

e. The MCO is not liable for the enrollee's court ordered assessment if the MCO provided the name of an inpatient facility and the court ordered the evaluation at an out-of-plan facility.

6. Institutionalized Children

If inpatient or institutionalized services are provided in the MCO facility, or approved by the MCO for provision in a non-contracted facility, the MCO shall be financially liable for all children enrolled under this contract for the entire period for which capitation is paid. The MCO remains financially liable for the entire period a capitation is paid even if the child's medical status code changes, or the child's relationship to the original AFDC case changes.

7. Institutionalized Adults

The MCO is not liable for expenditures for any service to a person 21 to 64 years of age who is a resident of an institution for mental disease (IMD), except to the extent that expenditures for a service to an individual on convalescent leave from an IMD are reimbursed by Medicaid FFS.

8. Transportation Following Emergency Detention

The MCO shall be liable for the provision of medical transportation to the MCO-affiliated provider when the enrollee is under emergency detention or commitment and the MCO requires the enrollee to be moved to a participating provider, provided the transfer can be made safely. If a transfer requires a secured environment by local law enforcement officials (i.e., sheriff department, police department, etc.) the MCO shall not be liable for the cost of transfer. The MCO is not prohibited from entering into an MOU or agreement with local law enforcement agencies or with county agencies for such transfer.

9. Memoranda of Understanding (MOU)/Contract Requirement and Relations with other Human Service Agencies

The MCO shall develop a working relationship with community agencies involved in the provision of mental health and/or substance abuse services to enrollees. The MCO must work cooperatively with other community agencies, to treat mental health and/or substance abuse conditions as legitimate health care problems.

MCO must make a "good faith" attempt to negotiate either an MOU or a contract with the county. A "good faith" attempt is defined as a minimum of one face-to-face meeting between the MCO and the county in an attempt to develop either an MOU or a contract. If the County will not agree to a face-to-face meeting the MCO must maintain a written record of their attempt to meet and to otherwise negotiate either an MOU or a contract with the county. The MOU, contract, or written documentation of a "good faith" attempt must be available when requested by the Department. Failure of the MCO to have an MOU or contract or to have demonstrated a good faith effort, as specified by the Department, may result in the application by the Department of remedies specified under this contract.

D. Time Limit for Decision on Certain Referrals

Pay for covered services provided by a non-MCO provider to a disabled participant or to any participant pursuant to a court order (for treatment), effective with the receipt of a written request for referral from the non-MCO provider, and extending until the MCO issues a written denial of referral. This requirement does not apply if the MCO issues a written denial of referral within seven (7) days of receiving the request for referral.

E. Emergency Care

1. The MCO must promptly provide or pay for needed contract services for emergency medical conditions, and post-stabilization services as defined in this contract, regardless of whether the provider that furnishes the services has a contract with the entity. Nothing in this requirement mandates the MCO to reimburse for non-authorized post-stabilization services. Payment and liability requirements include, but are not limited to:

    a. Payments for qualifying emergencies (including services at hospitals or urgent care centers within the MCO service area(s)) are to be based on the medical signs and symptoms of the condition upon initial presentation. The retrospective findings of a medical work-up may legitimately be the basis for determining how much additional care may be authorized, but not for payment for dealing with the initial emergency. Liability for emergency services continues until the patient is stabilized and can be safely discharged or transferred.

b. Paying for an appropriate, medical screening examination to determine whether or not an emergency medical condition exists.

c. Cover the cost of emergency services regardless of whether the emergency room provider, hospital or fiscal agent notifies the MCO of the emergency screening and treatment within 10 calendar days of the member's presentation for emergency services.

d. The MCO is responsible for paying all ancillary charges relating to dental emergencies. These ancillary charges would include, but are not limited to, physician, anesthesia, pharmacy and emergency room in a hospital or freestanding ambulatory care setting.

e. When emergency services are provided by non-affiliated providers, be liable for payment only to the extent that Medicaid pays, including Medicare deductibles, or would pay, FFS providers for services to the Medicaid and BadgerCare population. In no case will the MCO be required to pay more than billed charges. This condition does not apply to: 1) Cases where prior payment arrangements were established, or (2) where there are specific subcontract agreements.

2. Memorandum of Understanding (MOU) or Contract with Hospitals/ Urgent Care Centers for the Provision of Emergency Services

The MCO should have a contract or an MOU with hospitals or urgent care centers within the MCO's service area to ensure prompt and appropriate payment for emergency services. Unless a contract or MOU specifies otherwise, the MCO is liable to the extent that FFS would have been liable for a situation that meets the definition of emergency. The Department reserves the right to resolve disputes between the MCO, hospitals, and urgent care centers regarding emergency situations based on the emergency medical condition definition in Article I of this contract.

3. Ambulance Services

a. The MCO may require submission of a trip ticket with ambulance claims before paying the claim. Claims submitted without a trip ticket need only be paid at the service charge rate.

b. The MCO will pay a service fee for ambulance response to a call in order to determine whether an emergency exists, regardless of the MCO's determination to pay for the call.

c. The MCO will pay for emergency ambulance services based on established Medicaid criteria for claims payment of these services.

d. MCO will either pay or deny payment of a complete claim for ambulance services within 45 days of receipt of the claim.

e. MCO will respond to appeals from ambulance providers within the time frame described in this contract. Failure will constitute MCO agreement to pay the appealed claim in full.

F. MCO Care Management Services

Care Management Model – The MCO will provide care coordination and case management services according to the definition of care coordination. As part of this model, MCO will employ care coordinators and case managers to arrange, assure delivery of, monitor and evaluate basic and comprehensive care, treatment and services to a person. Prior to the implementation of this contract, the MCO will develop guidelines for care management and submit them to the Department for review and approval. The MCO must receive Department approval for any subsequent changes to the guidelines prior to the implementation of such changes.

Care Management – The care coordinators and case managers will work together with the primary care providers as teams to provide appropriate services for MCO enrollees. The MCO must have a protocol for handling disputes between the MCO case manager and a case manager from another program. At a minimum, the following must be provided for each enrollee:

1. A comprehensive assessment for each enrollee. Comprehensive assessment guidelines must be pre-approved by the Department. Departmental approval of subsequent changes is required before they are implemented by MCO. The guidelines include the development of care plan. The care plan must include both appropriate medical and social services and be consistent with the primary care provider's clinical treatment plan and medical diagnoses, be member-centered, reflect the principles of recovery, and be culturally sensitive. The assessment process shall incorporate, to the greatest extent possible, the enrollee's unique perspective about how he/she views his/her recovery, experience, challenges, strengths, resources, and needs in each of the domains included in the assessment process. A face-to face interview is the preferred method of assessment and should be done if possible. (See Article VII-Enrollment and Disenrollment, F, Re-enrollment, regarding the need to perform a comprehensive assement on enrollees who are re-enrolling in the MCO.)

2. The assessment shall be comprehensive and consistent with the following:

   a. Be based upon known facts and recent information and evaluations and include assessment of functional status, co-existing mental health disorders, substance use disorders, physical or mental impairments and medical problems.

b. Be updated as new information becomes available.

c. Address the strengths, needs, recovery goals, priorities, preferences, values and lifestyle described by the enrollee.

d. Address age and developmental factors that influence appropriate outcomes, goals, and methods for addressing them where applicable.

e. Identify the cultural and environmental supports as they affect identified goals and desired outcomes and preferred methods for achieving the identified goals.

f. Identify the enrollee's recovery goals and understanding of options for treatment.

g. The assessment process shall address all of the following:

1) Diagnoses and health related services.
2) Mental health, substance use, and trauma.
3) Use of crisis services including emergency rooms, any history of criminal justice involvement, and hospitalizations or other institutionalizations.
4) Demographic information (including ethnicity, education, living situation/housing, legal status).
5) Activities of daily living (including bathing, dressing, eating).
6) Instrumental activities of daily living (including medication management, money management, and transportation).
7) Overnight care and employment.
8) Communication and cognition (ability to communicate memory).
9) Indirect supports (family, social, and community network).
10) General health and life goals.
11) Any other health-related domain identified by the Department.

3. MCO must contact the enrollee to schedule the comprehensive assessment as soon as possible after receiving the enrollment report. Monthly, the MCO shall submit a detailed report of assessments to the Department. The report will include enrollees with not yet scheduled assessments, pending assessments, and completed assessments along with the MCO notification dates and effective enrollment dates.

4. Patient status and care plan reviews and updates must be conducted at least annually or more frequently if indicated to ensure the development and implementation of current and appropriate care plans for each enrollee.

5. The care plan must be developed in consultation with the enrollee and the enrollee's legal guardian, if appropriate, with opportunity for the enrollee to provide input. Enrollee participation in the care plan process must be documented by the MCO, as well as a judgment of the enrollee's understanding of the care plan. A care plan should be developed within 30 days of the initial assessment. Assessment and care planning must be done in conjunction with each other. The enrollee and others involved in delivering services and providing informal supports should be involved in developing the care plan. The care plan should clearly identify who will provide which services. The care plan should identify which services the MCO will provide and which services will be provided by others and how these services will be coordinated. Care plan should address integration of mental health and physical health care services. All care plans must consider consumer choice and need. If the care plan is not provided to all providers listed on the plan, the case manager must document why. Care plans for persons with serious mental illness should be reviewed at least every six months. Any changes in the care plan must be explained to the enrollee or guardian and documented. Agreement between the MCO and enrollee regarding the care plan is a desired goal. When such agreement is not possible, the areas of disagreement, the reasons for disagreement and how the care plan will be implemented given the disagreement must be documented in the care plan. The initial care plan must be shared verbally with the enrollee and an offer made to provide a written copy of the initial care plan or summary. The MCO must develop a process to ensure that relevant information from the care plan is available and easily accessible to the enrollee. The MCO must exert reasonable efforts to ensure that the Medicaid covered services specified in the care plan are provided, including working with enrollees to remove barriers to care. In the event that the Medicaid covered services specified in the care plan do not occur, the MCO records must reflect the reasons why care specified in the care plan was not provided. For non-Medicaid covered services, the MCO must assure that the members are referred to appropriate providers or community resources.

G. Twenty-Four Hour Coverage

The MCO must provide all emergency contract services and post-stabilization services as defined in this contract 24 hours each day, seven (7) days a week, either by the MCO's own facilities or through arrangements approved by the Department with other providers. The MCO must:

1. Have one (1) toll-free or local telephone number that enrollees or individuals acting on behalf of an enrollee can call at any time to obtain assistance in determining if emergency services are needed, to obtain authorization for urgent care and to obtain authorization for transportation. This telephone number must provide access to individuals with authority to authorize treatment as appropriate. Responses to these calls must be

provided within 30 minutes. If the MCO fails to respond timely, the MCO will be liable for the cost of subsequent care related to that illness or injury incident whether treatment is in or out-of-plan and whether the condition is emergency, urgent, or routine.

Authorization here refers to the requirements defined in the Standard Enrollee Handbook Language, regarding the conditions under which an enrollee must receive permission from the MCO prior to receiving services from a non-MCO affiliated provider in order for the MCO to reimburse the provider.

2. Be able to communicate with a caller in the language spoken by the caller or the MCO will be liable for the cost of subsequent care related to that illness or injury incident whether treatment is in or out-of-plan and whether the condition is emergency, urgent, or routine. These calls must be logged with time, date and any pertinent information related to persons involved, resolution and follow-up instructions.

3. Notify the Department of any changes to this toll-free telephone number for emergency calls within seven (7) working days of change.

H. Thirty-Day Payment Requirement

Pay at least 90% of clean claims from subcontractors for covered medically necessary services within 30 days of receipt of clean claim, 99% within 90 days, and 100% within 180 days of receipt, except to the extent subcontractors have agreed to later payment. MCO agrees not to delay payment to subcontractors pending subcontractor collection of third party liability unless the MCO has an agreement with its subcontractor to collect third party liability.

I. MCO Claim Retrieval System

Maintain a claim retrieval system that can, on request, identify date of receipt, action taken on all provider claims (i.e., paid, denied, other), and when action was taken. MCO shall date stamp all provider claims upon receipt. In addition, maintain a claim retrieval system that can identify, within the individual claim, services provided and diagnoses of enrollees with nationally accepted coding systems: HCPCS including Level I CPT codes and Level II and Level III HCPCS codes with modifiers, ICD-9-CM diagnosis and procedure codes, and other national code sets such as place of service, type of service, and EOB codes. Finally, the claim retrieval system must be capable of identifying the provider of services by the appropriate Wisconsin Medicaid provider ID number assigned to all in-plan providers.

J. Provider Appeals

All providers must appeal first to the MCO if they disagree with the MCO's payment or non-payment of a claim. The MCO must respond to the appeal within 45 days.

1. The MCO must inform providers in writing of the MCO's decision to pay or deny the original claims, including:

    a. A specific explanation of the payment amount or specific reason for non-payment.

    b. A statement regarding the provider's rights to appeal to the MCO.

    c. The name of the person and/or function at the MCO to whom provider appeals should be submitted.

    d. An explanation of the process that the provider should follow when appealing MCO's decision:

        1) Include a separate letter or form clearly marked "appeal."

        2) Include the provider's name, date of service, date of billing, date of payment and/or nonpayment, enrollee's name and Medicaid ID number.

        3) Include the reason(s) the claim merits reconsideration.

        4) Address the letter or form to the person and/or function at the MCO that handles Provider Appeals.

        5) Send the appeal within 60 days of the initial denial or payment notice.

    e. A statement advising non-contracted providers of their right to appeal to the Department if the MCO fails to respond to the appeal within 45 days or if the provider is not satisfied with the MCO's response to the request for reconsideration. Appeals to the Department must be submitted in writing within 60 days of the MCO's final decision, or in the case of no response, within 60 days from the 45 day timeline allotted the MCO to respond.

2. The MCO must accept written appeals from providers within 60 days of the MCO's initial payment and/or nonpayment notice. The MCO must respond in writing within 45 days from the date of receipt of the request for reconsideration. If the MCO fails to respond within 45 days, or if the provider is not satisfied with the MCO's response, the provider may seek a final determination from the Department.

3. After a provider has appealed to the MCO according to the terms described above, and the provider disputes the termination, the provider may appeal to the Department for the final determination. Appeals must be submitted to the Department within 60 days of the date of written notification of the MCO's final decision resulting from a request for reconsideration, or, if the MCO fails to respond, within 60 days from the 45 day timeline allotted the MCO to respond. In exceptional cases, the Department may override the MCO's time limit for the submission of claims and appeals. The Department will not exercise it's authority in this regard unreasonably. The Department will accept written comments from all parties to the dispute prior to making a final decision. The Department has 45 days from the date of receipt of all written comments to inform the provider and the MCO of the final decision. If the Department's decision is in favor of the provider, the MCO will pay provider(s) within 45 days of notification of the Department's final determination. The MCO must accept the Department's determination regarding appeals of disputed claims.

K. Payments for Emergency Services and Post-Stabilization Services

MCO may have a contract or an MOU with hospitals or urgent care centers within the MCO's service area to ensure prompt and appropriate payment for emergency services. For situations where a contract or MOU is not possible, MCO must identify for hospitals and urgent care centers procedures that ensure prompt and appropriate payment for emergency services.

Such MOUs shall provide for:

1. The process for determining whether an emergency exists.

2. The requirements and procedures for contacting the MCO before the provision of urgent or routine care.

3. Agreements, if any, between the MCO and the provider regarding indemnification, hold harmless, or any other deviation from malpractice or other legal liability which would attach to the MCO or provider in the absence of such an agreement.

4. Payments for appropriate, medically necessary, and reasonable diagnostic tests to determine if an emergency exists.

5. Assurance of timely and appropriate provision of and payment for emergency services.

6. Unless a contract or MOU specifies otherwise, MCO is liable to the extent that FFS would have been liable for the emergency situation. The Department reserves the right to resolve disputes between the MCO,

hospitals and urgent care centers regarding emergency situations based on FFS criteria.

L. Pre-Existing Conditions

Assume responsibility for all covered medical conditions of each enrollee as of the effective date of coverage under the contract. The aforementioned responsibility shall not apply in the case of persons hospitalized at the time of initial enrollment, as provided for in Section M of this Article.

M. Hospitalization at the Time of Enrollment or Disenrollment

The MCO will not assume financial responsibility for enrollees who are hospitalized at the time of enrollment (effective date of coverage) until an appropriate hospital discharge.

1. The Department will be responsible for paying on a FFS basis all Medicaid-covered services during the hospitalization for an enrollee who is hospitalized at the time of enrollment.

2. Enrollees who are hospitalized at the time of disenrollment from the MCO shall remain the financial responsibility of the MCO. The financial liability of the MCO shall encompass all contract services and shall continue for the duration of the hospitalization, except:

    a. Where loss of Medicaid eligibility occurs; or

    b. Where disenrollment is due to medical status change to a code indicating institutionalized eligibility. In these two (2) exceptions, the MCO's liability shall not exceed the period for which it is capitated.

3. Hospitalization in this section is defined as an inpatient stay at a certified hospital as defined in HFS 101.03 (76), Wis. Adm. Code. Discharge from one (1) hospital and admission to another within 24 hours for continued treatment shall not be considered discharge under this section. Discharge is defined here as it is in the UB-92 Manual.

N. Non-discrimination in Employment

Comply with all applicable federal and state laws relating to non-discrimination and equal employment opportunity including s. 16.765, Wis. Stats., Federal Civil Rights Act of 1964, regulations issued pursuant to that Act and the provisions of Federal Executive Order 11246 dated September 26, 1985. MCO shall assure physical and program accessibility of all services to persons with physical and sensory disabilities pursuant to Section 504 of the Federal Rehabilitation Act of 1973, as amended (29 U.S.C. 794), all requirements imposed by the applicable Department regulations (45 CFR part 84) and all guidelines and interpretations

issued pursuant thereto, and the provisions of the Age Discrimination and Employment Act of 1967 and Age Discrimination Act of 1975.

Chapter 16.765, Wis. Stats., requires the following provision to be included in every contract executed by agencies of the State. The Contractor agrees to the following provisions: In connection with the performance of work under this contract, the Contractor agrees not to discriminate against any employee or applicant for employment because of age, race, religion, color, handicap, sex, physical condition, developmental disability as defined in s. 51.01(5), sexual orientation or national origin. This provision shall include, but not be limited to, the following: employment, upgrading, demotion or transfer; advertising; layoff or termination; rates of pay or other forms of compensation, and selection for training, including apprenticeship. Except with respect to sexual orientation, the Contractor further agrees to take affirmative action to ensure equal employment opportunities. The Contractor agrees to post in conspicuous places, available for employees and applicants for employment, notices to be provided by the contracting officer setting forth the provisions of the nondiscrimination clause.

With respect to provider participation, reimbursement, or indemnification, the MCO will not discriminate against any provider who is acting within the scope of the provider's license or certification under applicable state law, solely on the basis of such license or certification. This shall not be construed to prohibit an MCO from including providers to the extent necessary to meet the needs of the Medicaid population or from establishing any measure designed to maintain quality and control cost consistent with these responsibilities.

O. Affirmative Action (AA), Equal Opportunity, and Civil Rights Compliance (CRC)

The CRC Plan contains three (3) components: Affirmative Action, Civil Rights/Equal Opportunity, and Language Access. MCO that has more than 25 employees and receives more than $25,000 must submit an AA, Equal Opportunity, CRC and Language Access Plan. The MCO that has less than 25 employees and receives less than $25,000 must submit a Letter of Assurance and proof it is exempt from submitting Affirmative Action information in accordance with s. 16.675, Wis., Stats, and Adm. Code 50. MCO must submit language access information as part of the MCO certification application.

1. Affirmative Action Plan

   a. For agreements where the MCO has 25 employees or more employees and will receive $25,000 or more, the MCO shall complete the AA, CRC and Language Access sections of the Plan that may cover a two (2) or three (3) year period.

      MCO with an annual work force of less than 25 employees or less than $25,000 may be exempt from submitting the AA component of the Plan.

1) Exemptions from submitting AA Component requirements will be granted if:

a) The MCO receives a State contract for less than $25,000;

b) The MCO has less than 25 employees regardless of the dollar amount of the contract;

c) The MCO is a foreign company with a workforce of less than 25 employees in the U.S.;

d) The MCO is a federal government agency or a Wisconsin municipality; and

e) The MCO has a balanced workforce, as defined in Article I.

If the MCO is exempt from submitting an AA component because it has a balanced work force, the MCO must submit its "Work Force Analysis Form, a Request for Exemption from Submitting AA Component."

If the MCO is exempt from submitting an AA component for other reasons, the MCO must submit a Request for Exemption from Submitting an AA Component. Exempt the MCO if it does not have a balanced work force in specific job groups that are required to develop and submit a recruitment strategy to address under-representation of that job group.

b. AA component is written in detail and explains the MCO's program. The AA component must be prepared in accordance to the most recently revised AA, Equal Opportunity, CRC and Language Access Plan Instruction and Manual for the funding period covering April 1, 2006, to December 31, 2007.

c. In addition, for agreements of $25,000 or more and with 25 employees, the MCO shall conduct, keep on file, and update annually, a separate and additional accessibility self-evaluation of all programs and facilities, including employment practices for compliance with the Americans with Disabilities (ADA) Title I regulations, unless an updated self-evaluation under Section 503 of the Rehabilitation Act of 1973 exists that meets the ADA requirements. For technical assistance on all aspects of the Civil Rights Compliance, MCO is to contact the Department's AA/CRC Office at:

The Department of Health and Family Services
1 W. Wilson Street, Room 555
P.O. Box 7850
Madison, WI 53707-7850
(608) 266-9372 (voice)
(608) 266-2555 (TTY)

d. The MCO must file its AA Plan within 15 days after the award of a contract. The Plan must be submitted to:

The Department of Health and Family Services
Office of Affirmative Action and Civil Rights Compliance
P.O. Box 7850
Madison, WI 53707-7850

2. Civil Rights Compliance (CRC) Plan

a. For agreements for the provision of services to enrollees, the MCO must comply with Civil Rights requirements. MCO with an annual work force of less than 25 employees or receiving less than $25,000 is not required to submit a CRC Plan, but must, at a minimum, submit a Letter of Assurance that the MCO will comply with all federal and state laws that address nondiscrimination in service delivery.

b. The MCO must submit to the Department's AA/CRC Office proof that it has complied with all the requirements in the revised AA, Equal Opportunity, CRC and Language Access Plan Instructions and Manual for Profit and Non-Profit Entities for meeting equal opportunity requirements under Title VI and VII of the Civil Rights Act of 1964; Sections 503 and 504 of the Rehabilitation Act of 1973; Title VI and XVI of the Public Health Service Act; the Age Discrimination in Employment Act of 1967; the Age Discrimination Act of 1975; the Omnibus Reconciliation Act of 1981; the Americans with Disabilities Act of 1990; and the Wisconsin Fair Employment Act. If a Plan was submitted and approved during the previous year, a Plan update must be submitted for this contract period.

1) No otherwise qualified person shall be excluded from participation in, be denied the benefits of, or otherwise be subject to discrimination in any manner on the basis of race, color, national origin, sexual orientation, religion, sex, or disability of age. This policy covers eligibility for and access to service delivery, and treatment in all programs and activities. All employees of the MCO are expected to

support goals and programmatic activities relating to nondiscrimination in service delivery.

2) No otherwise qualified person shall be excluded from employment, be denied the benefits of employment or otherwise be subject to discrimination in employment in any manner or term of employment on the basis of age, race/ethnicity, religion, sexual orientation, color, sex, national origin or ancestry, disability (as defined in Section 504 of the Rehab Act and the ADA) arrest or conviction record, marital status, political affiliation, military participation, the use of legal products during non-work hours, non-job related genetic and honesty testing. All employees are expected to support goals and programmatic activities relating to non-discrimination in employment.

3) The MCO must post the Equal Opportunity Policy, the name of the Equal Opportunity Coordinator and the discrimination complaint process in conspicuous places available to applicants and clients of services, and applicants for reemployment and employees. The complaint process will be according to Department standards and made available in languages and formats understandable to enrollees, applicants, and employees. The Department will continue to provide appropriate translated program brochures and forms for distribution.

4) The MCO agrees to comply with all of the requirements in the revised Department AA, Equal Opportunity, CRC and Language Access Plan for Profit and Non-Profit Entities and their subcontractors for the contract period.

5) These requirements apply to any subcontracts or grants. The MCO has responsibility for ensuring that its subcontractors or sub-grantees also comply with all of the requirements of the plan.

6) The Department will monitor the Civil Rights Compliance of the MCO. The Department will conduct reviews to ensure that the MCO is ensuring compliance by its subcontractors or subgrantees according to the guidelines in the AA, Equal Opportunity, CRC and Language Access Compliance Plan. The MCO agrees to comply with Civil Rights monitoring reviews, including the examination of records and relevant files maintained by the MCO, as well as interviews with staff, clients, and applicants for services, subcontractors, grantees, and referral agencies. The reviews will be conducted according to Department

procedures. The Department will also conduct reviews to address immediate concerns of complainants.

7) The MCO agrees to cooperate with the Department in developing, implementing and monitoring corrective action plans that result from complaint investigations or monitoring efforts.

P. Cultural Competency

1. MCO shall address the special health needs of enrollees such as those who are low income or members of a minority population group needing specific culturally competent services. MCO shall incorporate in its policies, administration, and service practice the values of:

   a. Recognizing members' beliefs.

   b. Addressing cultural differences in a competent manner.

   c. Fostering in staff/providers attitudes and interpersonal communication styles, which respect enrollees' cultural backgrounds.

   MCO shall have specific policy statements on these topics and communicate them to subcontractors.

2. MCO shall encourage and foster cultural competency among providers. MCO shall, when appropriate, permit enrollees to choose providers from among the MCO's network based on cultural preference. MCO shall permit enrollees to change primary providers based on the provider's ability to provide services in a culturally competent manner. Enrollees may submit grievances to the MCO and/or the Department related to inability to obtain culturally appropriate care, and the Department may, pursuant to such grievance, permit an enrollee to disenroll and enroll.

Q. Enrollee Handbook, Education and Outreach for New Enrollees

1. Within one (1) week of initial assessment or enrollment notification to the MCO, annually thereafter, and whenever requested by enrollee, guardians or authorized representatives, provide to each enrollee an enrollee handbook written at a sixth grade reading comprehension level and which at a minimum includes information about:

   a. The telephone number that can be used for assistance in obtaining emergency care or for prior authorization for urgent care.

   b. Information on contract services offered by the MCO.

c. Location of facilities.

d. Hours of service.

e. Informal and formal grievance procedures, including notification of the enrollee's right to a fair hearing.

f. Grievance appeal procedures.

g. HealthCheck.

h. Family planning policies.

i. Policies on the use of emergency and urgent care facilities.

j. Providers and whether the provider is accepting new "enrollees."

2. As needed, the MCO must provide periodic updates to the handbook, and explain changes in the above policies. All changes must be approved by the Department prior to printing.

3. When the MCO reprints their enrollee handbooks, they must include all of the changes to the standard language as specified in the contract.

4. Enrollee handbooks (or other substitute enrollee information approved by the Department which explains MCO services and how to use the MCO) shall be made available in at least the following languages: Spanish, , Russian and Hmong if the MCO has enrollees who are conversant only in those languages. The handbook must tell enrollees how to obtain a copy of the handbook in those languages. The Department will translate the standard handbook language into three (3) specified languages. The MCO may use the translated standard handbook language as appropriate to its service area. However, the MCO must have local resources review the final handbook language to ensure that the appropriate dialect(s) is/are used in the standard translation. The MCO must also arrange for translation into any other dialects appropriate for its enrollees.

5. MCO may create enrollee handbook language that they believe is simpler than the standard language but the Department must approve this substitute language. MCO must also independently arrange for the translation of non-standard language.

6. MCO shall submit their enrollee handbooks for review and approval within 60 days of signing the contract for 2006.

7. Standard language on several subjects, including HealthCheck, family planning, grievance and appeal rights, other enrollee rights including those under Section 51.61, Wisconsin State Statutes and HFS 94, Wisconsin

Administrative Code, conversion rights, and emergency and urgent care shall appear in all handbooks. Any exceptions to the standard must be approved in advance by the Department, and will be approved only for exceptional reasons. Standard language may change during the course of the contract period, if there are changes in federal or state laws, rules or regulations, in which case the new language will have to be inserted into the enrollee handbooks as of the effective date of any such change.

8. In addition to the above requirements for the enrollee handbook, the MCO must perform other education and outreach activities for new enrollees. The MCO must submit to the Department for prior written approval an education and outreach plan targeted towards new enrollees. This outreach plan will be examined by the Department during pre-contract review. New enrollees are listed as "ADD-New" on the enrollment reports. The plan must identify at least two (2) educational/outreach activities the MCO will undertake to tell new enrollees how to access services within the MCO network. The plan must include the frequency (i.e., weekly, monthly, etc.) of the activities, the person within the MCO responsible for the activities, and how the activities will be documented and evaluated for effectiveness.

R. Approval of Marketing and Informing Materials

1. Marketing and Informing Materials - As used in this section, "marketing materials, other marketing activities, and informing materials" include the production and dissemination of any informing materials, marketing plans, marketing materials, and other marketing activities that refer to Medicaid or Title XIX or are intended for Medicaid recipients.

2. Department Approval of Marketing and Informing Materials – The MCO will submit to the Department for prior written approval all informing materials, marketing plans, and all marketing materials and other marketing activities that refer to Medicaid or Title XIX or are intended for Medicaid recipients. This requirement includes marketing or informing materials that are produced by providers under contract to the MCO or owned by the MCO in whole or in part.

   Marketing plans and informing materials must be written at a "sixth grade comprehensive level" and will be reviewed by the Department in a manner that does not unduly restrict or inhibit the MCO's informing and marketing plans. When applying this provision to specific marketing plans, informing materials and/or activities, the entire content and use of the informing/marketing materials or activities shall be taken into consideration. All materials will be reviewed as follows:

   a. The Department will review and either approve, approve with modifications, or deny all marketing or informing material within 10 working days of receipt of the informing materials. If the MCO

does not receive a response from the Department within 10 business days, the MCO must contact the Contracts Section Chief in the Bureau of MHCP. A response will be prepared within two business days of this contact.

b. Time-sensitive marketing or informing material must be clearly marked time-sensitive by the MCO and will be approved, approved with modifications, or denied by the Department within three (3) business days. The Department reserves the right to determine whether the material is, indeed, time-sensitive.

c. The Department will not approve any materials which are deemed to be confusing, fraudulent, misleading, or do not accurately reflect the scope and philosophy of the Medicaid program and/or its covered benefits.

d. Problems and errors subsequently identified by the Department must be corrected by the MCO when they are identified. MCO agrees to comply with Ins. 6.07 and 3.27, Wis. Adm. Code, and practices consistent with the Balanced Budget Act of 1997, P.L. 105-33, sec. 4707 (a) [42 USC s. 1396v(d)(2)].

3. Prohibited Practices - The following marketing practices are prohibited:

a. Practices that are discriminatory.

b. Practices that seek to influence enrollment in conjunction with the sale of any other insurance product.

c. Direct and indirect cold calls, either door-to-door or telephonic.

d. Offer of material or financial gain to potential members as an inducement to enroll.

e. Activities and material that could mislead, confuse, or defraud enrollees.

f. Materials that contain false information.

g. Practices that are reasonably expected to have the effect of denying or discouraging enrollment.

4. MCO Agreement to Abide by Marketing/Informing Criteria – The MCO agrees to engage only in marketing activities and distribute only those informing and marketing materials that have been pre-approved in writing. Any activities must occur in its entire service area and only as indicated in the agreement. If the MCO fails to abide by marketing requirements the MCO may be subject to any and all sanctions available under Article IX.

In determining any sanctions, the Department will take into consideration any past unfair marketing practices, the nature of the current problem and the specific implications on the health and well being of the Medicaid enrollees. In the event that the MCO's affiliated provider fails to abide by these requirements, the Department will evaluate whether the MCO should have had knowledge of the marketing issue and the MCO's ability to adequately monitor ongoing future marketing activities of the subcontractor(s).

S. Choice of Health Professional

Offer each enrollee covered under this contract the opportunity to choose a primary health care professional affiliated with the MCO, to the extent possible. If the MCO assigns enrollees to primary care providers, then the MCO shall notify enrollees of the assignment. The MCO must permit Medicaid enrollees to change primary providers at least twice in any calendar year, and to change primary providers more often than that for just cause, just cause being defined as lack of access to quality, culturally appropriate, health care. Such just cause will be handled as a formal grievance. If the MCO has reason to lock-in an enrollee to one (1) primary care provider and/or pharmacy in cases of difficult case management, the MCO must submit a written request in advance of such lock-in to the Department's Contract Specialist. Culturally appropriate care in this section means care by a provider who can relate to the enrollee and who can provide care with sensitivity, understanding, and respect for the enrollee's culture.

T. Quality Assessment/Performance Improvement (QAPI)

1. Regulation - The MCO QAPI program must conform to requirements of 42 CFR, Part 400, Medicaid Managed Care Requirements, Subpart D, QAPI. The program must also comply with 42 Code of Federal Regulations (CFR) 434.34 which states that the MCO must have a QAPI system that:

    a. Is consistent with the utilization control requirement of 42 CFR 456.

    b. Provides for review by appropriate health professionals of the process followed in providing health services.

    c. Provides for systematic data collection of performance and patient results.

    d. Provides for interpretation of this data to the practitioners.

    e. Provides for making needed changes.

2. QAPI Program

a. The MCO must have a comprehensive QAPI program that maintains and improves the quality of care provided to Wisconsin Medicaid program recipients. The MCO must evaluate the overall effectiveness of its QAPI program annually to determine whether the MCO has demonstrated improvement, where needed in the quality of care and services provided to its enrolled Medicaid population.

   The MCO must have documentation of all aspects of the QAPI program available for Department review upon request. The Department may perform off-site and on-site QAPI reviews to ensure that the MCO is in compliance with contract requirements. The review may include: On-site visits; staff and enrollee interviews; medical record reviews; review of all QAPI procedures, reports, committee activities, including credentialing and recredentialing activities, corrective actions and follow up plans; peer review process; review of the results of the member satisfaction surveys; and review of staff qualifications.

b. The MCO must have a written QAPI work plan that is ratified by the board of directors and outlines the scope of activity and the goals, objectives, and time lines for the QAPI program. New goals and objectives must be set at least annually based on findings from quality improvement activities and studies and results of the MCO on DHCF enrollee satisfaction surveys and the subset of Department-approved performance measures.

c. The MCO's governing body is ultimately accountable to the Department for the quality of care provided to MCO members. Oversight responsibilities of the governing body include, at a minimum: approval of the overall QAPI program and an annual QAPI plan; designation of an accountable entity or entities within the organization to provide oversight of QAPI; review of written reports from the designated entity on a periodic basis which include a description of QAPI activities, progress on objectives, and improvements made; formal review on an annual basis of a written report on the QAPI program; and directing modifications to the QAPI program on an ongoing basis to accommodate review findings and issues of concern within the MCO.

d. The QAPI Committee shall be in an organizational location within the MCO such that it can be responsible for all aspects of the QAPI program. The Committee membership must be interdisciplinary and be made up of both providers and administrative staff of the MCO, including, but not limited to:

   1) A variety of health professions (e.g., pharmacy, physical therapy, nursing, etc.).

2) Qualified professionals (e.g., specializing in mental health, substance abuse, dental care, etc.) on a consulting basis when an issue related to subspecialty areas arises.

3) A variety of medical disciplines (e.g., medicine, surgery, radiology, etc.).

4) A psychiatrist and an individual with specialized knowledge and experience with persons with disabilities.

5) MCO management or governing body.

6) The membership of the QAPI committee must include enrollees. The MCO must demonstrate orientation of consumers to participate fully on the QAPI committee. The MCO must also have a system to receive enrollee input on quality related issues, document the input received, document the MCO's response to the input, including a description of any changes or studies it implemented as the result of the input, and document feedback to enrollees in response to input received. The MCO response must be timely. The Department will review the MCO's system to involve consumers in the QAPI process.

e. The committee must meet on a regular basis, but not less frequently than quarterly. The activities of the QAPI Committee must be documented in the form of minutes and reports. The QAPI Committee must be accountable to the governing body. Documentation of Committee minutes and activities must be available to the Department upon request.

f. QAPI activities of MCO providers and subcontractors, if separate from the MCO QAPI activities, shall be integrated into the overall MCO/QAPI program. Requirements to participate in QAPI activities, including submission of complete encounter data, must be incorporated into all provider and subcontractor contracts and employment agreements. The MCO QAPI program shall provide feedback to the providers/subcontractors regarding the integration of, operation of, and corrective actions necessary in provider/ subcontractor QAPI efforts.

Other management activities (Utilization Management (UM), Risk Management, Customer Service, Complaints and Grievances, etc.) must be integrated with the QAPI program. Physicians and other health care practitioners and institutional providers must actively cooperate and participate in the MCO's QAPI activities.

The MCO remains accountable for all QAPI functions, even if certain functions are delegated to other entities. If the MCO delegates any activities to contractors, the conditions of this agreement must be met.

There must be evidence that MCO management representatives and providers participate in the development and implementation of the QAPI plan of the MCO. This provision shall not be construed to require that MCO management representatives and providers participate in every QAPI committee or subcommittee of the QAPI program.

g. The MCO must designate a senior executive to be responsible for the operation and success of the QAPI program. If this individual is not the MCO Medical Director, the Medical Director must have substantial involvement in the QAPI program. The designated individual shall be accountable for the QAPI activities of the MCO's own providers, as well as the MCO's subcontracted providers.

h. The qualifications, staffing level and available resources must be sufficient to meet the goals and objectives of the QAPI program and related QAPI activities. Such activities include, but are not limited to, monitoring and evaluation of important aspects of care and services, facilitating appropriate use of preventive services, monitoring provider performance, provider credentialing, involving members in QAPI initiatives and conducting performance improvement projects.

Written documentation listing the staffing resources that are directly under the organizational control of the person who is responsible for QAPI (including total FTEs, percentage of time dedicated to QAPI, background and experience, and role) must be available to the Department upon request.

3. Monitoring and Evaluation

a. The QAPI program must monitor and evaluate the quality of clinical care on an ongoing basis. Important aspects of care (i.e., acute, chronic conditions, high volume, high risk, preventive care and services) must be studied and prioritized for performance improvement and/or the development of practice guidelines. Standardized quality indicators must be used to assess improvement, assure achievement of minimum performance levels, monitor adherence to guidelines and identify patterns of over-utilization and under-utilization. The measurement of quality indicators, selected by the MCO for areas other than those included in the Department's approved performance measure must be

supported by appropriate data collection and analysis methods and must be used to improve clinical care and services.

b. Provider must be measured against practice guidelines and standards adopted by the QAPI Committee. Areas identified for improvement must be tracked and corrective actions taken when warranted. The effectiveness of corrective actions must be monitored until problem resolution occurs. Reevaluation must occur to assure that the improvement is sustained.

c. The MCO must use appropriate clinical performance indicators and multi-disciplinary teams to analyze and address data on systems issues.

d. The MCO must also monitor and evaluate care and services in certain priority clinical and non-clinical areas specified.

e. The MCO must make documentation available to the Department upon request regarding quality improvement studies on plan performance, which relate to the enrolled population. See reporting requirements in "Performance Improvement Priority Areas" (Article III, Section T, item 13).

f. The MCO must develop or adopt practice guidelines and disseminate them to providers and/or to enrollees as appropriate upon request. The guidelines must be based on valid and reliable medical evidence or consensus of health professionals; consider the needs of the enrollees; developed or adopted in consultation with the contracting health professionals, and reviewed and updated periodically. Decisions with respect to UM, enrollee education, coverage of services, and other areas to which the practice guidelines apply must be consistent with the guidelines. Application of the guidelines must be based on the individual clinical situation.

4. Access

a. Access to Medical Care – The MCO must provide medical care to its Medicaid enrollees that is as accessible to them, in terms of timeliness, amount, duration, and scope, as those services are to non-enrolled Medicaid recipients within the MCO service area.

b. Network Adequacy – The MCO must ensure that its delivery network is sufficient to provide adequate access to all services covered under this agreement. In establishing the network, the MCO must consider:

1) The anticipated Medicaid enrollment.

2) The expected utilization of services, considering enrollee characteristics and health care needs.

3) The number and types of providers (in terms of training experience and specialization) required to furnish the contracted services.

4) The number of network providers not accepting new patients.

5) The geographic location of providers and enrollees, distance, travel time, normal means of transportation used by enrollees and whether provider locations are accessible to persons with disabilities.

6) In addition to any primary care provider, a female enrollee must have direct access to a women's health specialist within the network for covered women's routine and preventive health care services.

7) Provision for a second opinion from a qualified network provider upon enrollee request, subject to referral procedures approved by the Department. If an appropriately qualified provider is not available within the network, arrange for a second opinion outside the network at no charge to the enrollee.

8) Adequate and timely coverage of services provided out of network, when the required medical service is not available within the MCO network. In addition, the MCO must update the documentation and assurance to the Department with respect to network adequacy whenever there has been a significant change, as defined by the Department, in the MCO's operation that would affect adequate capacity and services, including charges in MCO service, benefits, geographic service areas, payments, or enrollment of a new population in the MCO (42 CFR s. 428.207(c)(2)(i-ii).

9) Network providers are credentialed as required by this contract.

MCO must provide documentation and assurance of the above network adequacy criteria as required by the Department. In addition, the MCO must update the documentation and assurance to the Department with respect to network adequacy whenever there has been a significant change, as defined by the Department, in the MCO's operations that would affect adequate capacity and

services, including changes in MCO services, benefits, geographic service areas, payments or enrollment of a new population in the MCO.

c. Written Protocols – The MCO must have written protocols to ensure that enrollees have access to screening, diagnosis and referral, and appropriate treatment for those conditions and services covered under the Wisconsin Medicaid program. The MCO must also provide medically high risk prenatal care within two (2) weeks of the enrollee's request for an appointment, or within three (3) weeks if the request is for a specific MCO provider.

The MCO's protocols must include methods for identification, outreach to and screening/assessment of enrollees with special health care needs.

d. Written Standards – The MCO must have written standards for the accessibility of care and services that are communicated to providers and monitored. The standards must include the following: waiting times for care at facilities; waiting times for appointments; specify that providers' hours of operation do not discriminate against Medicaid enrollees; and whether or not provider(s) speak member's language. The MCO must take corrective action if its standards are not met.

5. Health Promotion and Disease Prevention Services

a. The MCO must identify at-risk populations for preventive services and develop strategies for reaching members included in this population. LHDs and community-based health organizations can provide the MCO with special access to vulnerable and low-income population groups, as well as settings that reach at-risk individuals in their communities, schools and homes. Public health resources can be used to enhance the MCO's health promotion and preventive care programs.

b. The MCO shall develop strategies for relapse prevention and for educating members with chronic diseases in self-management techniques. The MCO shall integrate promotion and prevention services into the member's care plan through the use of guidelines, protocols, screenings, and member education.

c. The MCO must have mechanisms for facilitating appropriate use of preventive services and educating members on health promotion. At a minimum, an effective health promotion and prevention program includes: Tracking of preventive services, practice guidelines for preventive services, yearly measurement of

performance in the delivery of such services, and communication of this information to providers and members.

d. The MCO must develop and ensure implementation of program initiatives to address the specific clinical needs that have a higher prevalence in the Medicaid population. The Medicaid population has traditionally been a high user of the public health system. The Department strongly advocates the development of collaborative relationships among the MCO, local heath departments, community-based behavioral health treatment agencies (both public and private), and other community health organizations to achieve improved services. Linkages across Medicaid managed care and public health agencies are essential elements for the achievement of the public health objectives, thereby potentially reducing the quantity and intensity of services the MCO needs to provide.

6. Provider Selection (Credentialing) and Periodic Evaluation (Recredentialing)

a. The MCO must have written policies and procedures for provider selection and qualifications. For each practitioner, including each member of a contracting group that provides services for the MCO enrollees, initial credentialing must be based on a written application, primary source verification of licensure, disciplinary status, eligibility for payment under Medicaid and certified under Medicaid. The MCO's written policies and procedures must identify the circumstances in which site visits are appropriate in the credentialing process.

The MCO may not employ or contract with providers excluded in Federal Health Care program under either Section 1128 or Section 1128A of the Social Security Act.

b. The MCO must periodically monitor [no less than every three (3) years] the provider's documented qualifications to assure that the provider still meets the MCO's specific professional requirements.

c. The MCO must also have a mechanism for considering the provider's performance. The recredentialing method must include updating all the information (except medical education) utilized in the initial credentialing process. Performance evaluation must include information from the QAPI system, reviewing member complaints, and the UM system.

d. The selection process must not discriminate against providers such as those serving high-risk populations, or specializing in conditions that require costly treatment. The MCO must have a process for

receiving advice on the selection criteria for credentialing and recredentialing practitioners in the MCO network.

If the MCO declines to include individual or groups of providers in its network, the MCO must give the affected providers written notice of the reason for its decision.

e. If the MCO delegates selection of providers to another entity, the organization retains the right to approve, suspend, or terminate any provider selected by that entity.

f. The MCO must have a formal process of peer review of care delivered by providers and active participation of the MCO's contracted providers in the peer review process. This process may include internal medical audits, medical evaluation studies, peer review committees, evaluation of outcomes of care, and systems for correcting deficiencies. The MCO must supply documentation of its peer review process upon request.

g. The MCO must have written policies that allow it to suspend or terminate any provider for quality deficiencies. The policies shall include an appeals process that is available to the provider that conforms to the requirements of the Health Care Quality Improvement Act of 1986 (42 USC 11101 et. Seq.).

h. The names of individual practitioners and institutional providers who have been terminated from the MCO provider network as a result of quality issues must be immediately forwarded to the Department and reported to other entities as required by law (42 USC 11101 et. Seq.).

i. The MCO must determine and verify at specified intervals that:

1) Each provider, other than an individual practitioner is licensed to operate in the State, if licensure is required, and in compliance with any other applicable state or federal requirements; and

2) The MCO verifies provider accreditation status, if the provider claims accreditation, or is determined by the MCO to meet standards established by the MCO itself.

j. Exception to Credentialing and Recredentialing Requirements— These standards do not apply to:

1) Providers who practice only under the direct supervision of a physician or other provider, and hospital-based providers such as emergency room physicians, anesthesiologists, and

other providers who provide services only incident to hospital services.

2) Providers who contract independently with the MCO.

7. Enrollee Feedback On Quality Improvement

a. The MCO must have a process to maintain a relationship with its enrollees that promote two (2) way communication and contribute to quality of care and service. The MCO must treat enrollees with respect and dignity, consistent with the principles of recovery.

b. The Department will conduct a satisfaction with care survey of a representative sample of enrollees. The Department will work with the MCO to develop the survey instrument and plan. The MCO shall have systems in place for acting on survey results and shall report to the Department any quality management projects planned in response to survey results.

c. The MCO will find additional ways to involve Medicaid members in quality improvement initiatives and in soliciting member feedback on the quality of care and services the MCO provides. Other ways to bring Medicaid recipients into the MCO's efforts to improve the health care delivery system include but are not limited to: focus groups, enrollee advisory councils, member participation on the governing board, the QAPI committees or other committees; or task forces related to evaluating services. All efforts to solicit feedback from Medicaid members must be approved by the Department. The MCO plan to involve Medicaid recipients must be available to the Department if requested.

8. Medical Records

a. The MCO must have policies and procedures for participating provider medical records content and documentation that have been communicated to providers, and a process for evaluating its providers' medical records based on the MCO's policies. These policies must address patient confidentiality, organization and completeness, tracking, and important aspects of documentation such as accuracy, legibility, and safeguards against loss, destruction, or unauthorized use. The MCO must also have confidentiality policies and procedures that are applicable to administrative functions that are concerned with confidential patient information. Those policies must include information with respect to disclosure of enrollee-identifiable medical record and/or enrollment information, and specifically provide:

1) That enrollees may review and obtain copies of medical records information that pertain to them.

2) That the policies above must be made available to enrollees upon request.

b. Patient records must be maintained in an organized manner (by the MCO and/or by the MCO's subcontractors) that permits effective enrollee care. They must reflect all aspects of member care and be readily available for member encounters, for administrative purposes, and for Department review.

c. Because the MCO is a contractor of the state and is therefore (only for the limited purpose of obtaining medical records of its enrollees) entitled to obtain medical records according to Wis. Adm. Code, HFS 104.01(3), the Department requires Medicaid-certified providers to release relevant records to the MCO to assist in compliance with this section. If the MCO has not specifically addressed photocopying expenses in its provider contracts or other arrangements, the MCO is liable for charges for copying records only to the extent that the Department would reimburse on a FFS basis.

d. The MCO must have written confidentiality policies and procedures in regard to individually identifiable patient information. Policies and procedures must be communicated to MCO staff, members, and providers. The transfer of medical records to out-of-plan providers or other agencies not affiliated with MCO (except for the Department) must comply with applicable state and federal law.

e. The MCO must have written quality standards and performance goals for participating provider medical record documentation and be able to demonstrate, upon request of the DHFS, that the standards and goals are communicated to providers. The MCO must actively monitor compliance with established standards and provide documentation of monitoring for compliance with standards and goals upon request of the Department.

f. Medical records must be readily available for MCO-wide QAPI and UM activities and provide adequate medical and other clinical data required for QAPI/UM activities and Department use.

g. The MCO must have adequate policies for transfer of medical records to ensure continuity of care when enrollees are treated by more than one (1) provider. This may include transfer to LHDs subject to the receipt of a signed authorization form as specified in

d., above (with the exception of immunization status information, which does not require enrollee authorization).

h. The MCO shall use its best efforts to assist enrollees and their authorized representatives in obtaining complete records, including progress notes, within 10 working days of the record request. This requirement shall take effect for MCO when it takes effect for FFS Medicaid providers.

i. Requests for completion of residual functional capacity evaluation forms and other impairment assessments, such as queries as to the presence of a listed impairment, shall be provided within 10 working days of request (at the discretion of the individual provider and subject to the provider's medical opinion of its appropriateness) and according to the other requirements listed above; the MCO and its providers and subcontractor may charge the enrollee, authorized representative, or other third party a reasonable rate for the completion of such forms and other impairment assessments. Such rates may be reviewed by the Department for reasonableness and may be modified based on this review.

j. Minimum medical record documentation per chart entry or encounter must conform to the Wis. Adm. Code, Chapter HFS 106.02, (9)(b), medical record content.

9. Utilization Management (UM)

a. Documented Policies – The MCO must have documented policies and procedures for all UM activities that determine medical necessity and the approval or denial of medical services. Qualified professionals must be involved in any decision-making that requires professional or discipline-specific clinical judgment. The decision to deny, reduce or authorize a service that is less than requested must be made by a health professional with appropriate clinical expertise in treating the affected enrollee's condition(s). The MCO must communicate to providers criteria used to determine medical necessity and appropriateness. The criteria for determining medical necessity may not be more stringent than HFS 101.03 (96m), Wis. Adm. Code. Documentation of denial of services must be available to the Department upon request.

b. If the MCO delegates any part of the UM program to a third party, the delegation must meet the requirements in this contract.

c. If the MCO utilizes telephone triage, nurse lines or other demand management systems, the MCO must document review and approval of qualification criteria of staff and of clinical protocols

or guidelines used in the system. The system's performance will be evaluated annually in terms of clinical appropriateness.

d. The policies specify time frames for responding to requests for initial and continued determinations, specify information required for authorization decisions, provide for consultation with the requesting provider when appropriate, and provide for expedited response to requests for authorization of urgently needed services. In addition, the MCO must have in effect mechanisms to ensure consistent application of review criteria for authorization decisions (interrater reliability).

Within the time frames specified, the MCO must give the enrollee and the requesting provider written notice of:

1) The decision to deny, limit, reduce, delay, or terminate a service along with the reasons for the decision.

2) The enrollee's right to file a grievance or request a state fair hearing.

Authorization decisions must be made within the following time-frames and in all cases as expeditiously as the enrollee's condition requires:

1) Within 14 calendar days of the receipt of the request, or

2) Within three (3) business days if the physician indicates or the MCO determines that following the ordinary time frame could jeopardize the enrollee's health or ability to regain maximum function.

One extension of up to 14 calendar days may be allowed if the enrollee requests it or if the MCO justifies the need for more information.

On the date that the time frames expire, MCO gives notice that services authorization decisions are not reached. Untimely service authorizations constitute a denial and are thus adverse actions.

e. Criteria for decisions on coverage and medical necessity are clearly documented, are based on reasonable medical evidence, current standards of medical practice, or a consensus of relevant health care professionals, and are regularly updated.

f. The MCO oversees and is accountable for any functions and responsibilities that it delegates to any subcontractor.

g. Postpartum discharge policy for mothers and infants must be based on medical necessity determinations. This policy must include all follow-up tests and treatments consistent with currently accepted medical practice and applicable federal law. The policy must allow at least a 48-hour hospital stay for normal spontaneous vaginal delivery, and 96 hours for a cesarean section delivery, unless both the physician and the enrollee agree to a shorter stay. The MCO may not deny coverage, penalize providers, or give incentives or payments to providers or enrollees. Post hospitalization follow-up care must be based on the medical needs and circumstances of the mother and infant. The Department may request documentation demonstrating compliance with this requirement.

10. External Quality Review Contractor

a. The MCO must assist the Department and the external quality review organization under contract with the Department in completing all MCO reviews in accordance with protocols found as part of the Balanced Budget Act of 1997 (BBA). These protocols guide the external, independent review of the quality outcomes and timeliness of, and access to, services provided by the Medicaid MCO.

b. The MCO must assist the Department and the external quality review organization under contract with the Department in identification of provider and enrollee information required to carry out annual, external independent reviews of access, timeliness and quality outcomes based on on-site or off-site reviews. This includes arranging orientation meetings for physician office staff concerning medical chart review, and encouraging attendance at these meetings by MCO and physician office staff as necessary. The provider of service may elect to have charts reviewed on-site or off-site.

c. The purposes of the EQRO review are:

1) To validate data and information including performance measures submitted by the MCOs to the DHCF for the purpose of quality assessment. Validation may include the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis.

2) To validate MCO Performance Improvement Projects (PIPs) to ensure that PIPs are designed, conducted and reported in a methodologically sound manner.

3) To review compliance with structural and operation standards established by the state.

4) To provide DHCF and the MCO with information about their performance that is not available from other sources of data.

5) To provide information that will aid DHCF and the MCO in interpreting other sources of data, such as encounter data.

6) To provide insight and information about factors that influenced differences in program performance among similar populations.

7) To provide information that is useful to programs for their ongoing quality improvement processes.

8) To provide information that will be useful to DHCF in fulfilling its oversight role for developing the MCO's contract requirements.

d. When the external quality review organization under contract with the Department identifies an adverse quality finding that needs to be followed up on, the MCO must:

1) Assign a staff person(s) to conduct follow-up with the provider(s) concerning each adverse quality finding identified by the Department's external quality review organization, including informing the provider(s) of the finding and monitoring the provider's resolution of the finding.

2) Inform the MCO's QAPI committee of the final finding and involve the QAPI committee in the development, implementation and monitoring of the corrective action plan.

3) Submit a corrective action plan or an opinion in writing to the Department within 60 days that addresses the measures that the MCO and the provider intend to take to resolve the finding. MCO's final resolution of all potential Quality Improvement cases must be completed within six (6) months of MCO notification. A case is not considered resolved by the Department until the Department approves the response provided by the MCO and provider.

e. The MCO will facilitate training provided by the Department to its providers.

f. The results of the review will be made available to the Department, and MCO providers in a manner that does not disclose the identity of any individual enrollee, unless such identification is required to resolve an issue.

11. Dental Services Quality Improvement

The MCO QAPI committee and QAPI coordinator will review subcontracted dental programs quarterly to assure that quality dental care is provided and that the MCO and the contractor comply with the following:

a. MCO or MCO affiliated dental provider must advise the enrollee within 30 days of effective enrollment of the name of the dental provider and the address of the dental provider's site. The MCO or MCO affiliated dental provider must also inform the enrollee in writing how to contact his/her dentist (or dental office), what dental services are covered, when the coverage is effective, and how to appeal denied services.

b. The MCO or MCO affiliated dental provider who assigns all or some Medicaid MCO enrollees to specific participating dentists must give enrollees at least 30 days after assignment to choose another dentist. Thereafter, in accordance with the contract, the MCO and/or affiliated provider must permit enrollees to change dentists at least twice in any calendar year and more often than that for just cause.

c. MCO-affiliated dentists must provide a routine dental appointment to an assigned enrollee within 90 days after the request. Enrollee requests for emergency treatment must be addressed within 24 hours after the request is received.

d. Dental providers must maintain adequate records of services provided. Records must fully disclose the nature and extent of each procedure performed and should be maintained in a manner consistent with standard dental practice.

e. The MCO affirms by execution of this contract that the MCO's peer review systems are consistently applied to all dental subcontractors and providers.

f. The MCO must document, evaluate, resolve, and follow-up all verbal and written complaints they receive from Medicaid enrollees that are related to dental services.

12. Accreditation

    a. The Department encourages the MCO to actively pursue accreditation by the NCQA or the JCAHO, or other recognized accrediting body approved by the Department. 42 CFR s. 438.360 provides that the Department may recognize "a private national accrediting organization that CMS has approved as applying standards at least as stringent as Medicare under the procedures in s. 422.158."

       The Centers for Medicare and Medicaid Services (CMS) has recognized the following accrediting bodies: The National Committee for Quality Assurance (NCQA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the Accreditation Association for Ambulatory Health Care. The Department may recognize other accreditation bodies as they may qualify for such recognition.

    b. The achievement of full accreditation by an accreditation body approved by the Department and satisfaction of the requirements of the MCO Accreditation Incentive Program as specified by the Department will result in the MCO qualifying for the Accreditation Incentive.

       Where accreditation standards conflict with the standards set forth in this agreement, the agreement prevails unless the accreditation standard is more stringent.

13. Performance Improvement Priority Areas and Projects

    a. The MCO must develop and ensure implementation of program initiatives to address the specific clinical or non-clinical needs in the MCO's enrolled population served under this agreement. These priority areas must include clinical and non-clinical Performance Improvement topics. The Department strongly advocates the development of collaborative relationships among the MCO, local health departments, community-based behavioral health treatment agencies (both public and private), and other community health organizations to achieve improved services in priority areas. Linkage between the MCO and public health agency is an essential element for the achievement of the public health objectives, potentially reducing the quantity and intensity of services the MCO needs to provide. The Department and the MCO are jointly committed to on-going collaboration in the area of service and clinical care improvements by the development and sharing of "best practices" and use of encounter data-driven performance measures.

The MCO must annually monitor and evaluate the quality of care and services through performance improvement projects for at least two (2) of the listed areas; or the MCO may propose alternative performance improvement topics to be addressed by making a request in writing to the Department. In addition to the two (2) performance improvement projects required, the MCO may be required to conduct up to two (2) additional performance improvement initiatives and submit reports as required to achieve performance goals. The final or on-going status report for each project must be submitted by January 1, 2007, and January 1, 2008. The performance improvement topic must take into account: the prevalence of a condition among, or need for a specific service, by the MCO enrollees served under this agreement; enrollee demographic characteristics and health risks; and the interest of enrollees or purchasers in the aspect of care or services to be addressed.

1) The report for each performance improvement project must address each of the following points in order for the Department to evaluate the soundness and results of the projects submitted. The BCAP method for reporting outlined below is not mandated, but is an acceptable format for performance improvement projects. Other formats may be used as long as performance improvement project criteria outlined below is addressed.

2) Ten steps for completing a performance improvement project.

   a) Select a Study Topic

      (1) Is the topic important to the enrolled population?
      (2) Does it affect a significant portion of the enrollees (or specified sub-portion) and reflect a high-volume or high-risk condition of the population served?
      (3) Can it be affected by actions of the MCO?

   b) Define a Study Question.

      (1) Was the method and procedure used to study the topic clear?
      (2) Was the study question clearly stated and consistent throughout the study?
      (3) Is the study question specific and answerable?

c) Select Study Indicators

(1) Were the indicators objective, clear, and unambiguously defined?

(2) Are the indicators based on current clinical knowledge or health services research? (Healthcare guidelines)

(3) Do the indicators objectively measure either enrollee outcomes such as health or functional status, enrollee satisfaction, or valid proxies of these outcomes?

d) Identify the Study Population

(1) Is there a clear definition of who to include in the study?
(2) Did the study define an "at risk" population?
(3) Was the entire population included or was a sample used?
(4) If the entire population was included, were all enrollees captured by the data collection process used?

e) Utilize Sampling Methods (if applicable)

(1) Was a valid sample size calculated?
(2) Were valid sampling techniques used?

f) Data Collection

(1) Were the data fully described in detail?
(2) Were the data appropriate to answer the study question?
(3) Was the data collection process fully described?
(4) Was the data collection appropriate to collect the data?
(5) Was interrater reliability adequate?
(6) Did the loss of data or subjects affect the study?
(7) Was the study time frame clear?

g) Improvement Strategies

(1) Were interventions related to causes/barriers identified through data analysis?
(2) Were the interventions fully described?

(3) Can the interventions be widely implemented?
(4) Was the implementation process monitored for effectiveness?

h) Results and Interpretation of Findings

(1) Was the data collected fully reported?
(2) Did the study include comparisons to give meaning to the results?
(3) Is the norm or standard expressed in a specific numerical manner?
(4) Is the goal, norm or standard appropriate to this population?
(5) Did the study appropriately use statistical testing?
(6) Were the conclusions consistent with the results?
(7) Were data tables, figures, and graphs consistent with the text?
(8) Did the study consider its limitations?
(9) Did study conclude or imply causality when the supporting data is only correlational?
(10) Did the study include how to improve the study?
(11) Did the study present recommendations of the results appropriately?
(12) Did the report clearly state whether performance improvement goals were met? If not, is there a plan for future action?

i) Real Improvement Achieved

(1) Was statistically significant improvement achieved?
(2) Does the improvement in performance appear to be due to the planned intervention?
(3) What additional questions did the study raise? What are the next steps, if any, to study this question/topic?
(4) What will you do differently as a result of your study?

j) Sustained Improvement

(1) Was sustained improvement demonstrated through repeated measurements over comparable time periods?

b. Performance reporting will utilize standardized indicators appropriate to the performance improvement area or as specified in the Department's approved performance measures. Minimum performance levels must be specified for each performance improvement area, using normative standards derived from regional, national norms or from norms established by an appropriate practice organization. Goals for improvement for the "Priority Areas" listed in paragraph c. of this section, may be set by the MCO itself.

The MCO must ensure that improvements are sustained through periodic audits of relevant data and maintenance of the interventions that resulted in the improvement. The MCO agrees to open at least one (1) new performance improvement project during the contract period. In all cases, not less than two (2) performance improvement projects must be reported to the Department in any year and not less than two (2) different projects must be reported to the Department between 2006 and 2007. These projects are in addition to any that may be required as the result of sub-goal performance on any Department approved performance measures. However, if the MCO chooses to initiate or continue a project on a topic that coincides with a required project, the Department will accept the report as fulfilling both requirements during the next contract year.

The MCO must implement a performance improvement project in the area if a quality improvement opportunity is identified. The MCO must report to the Department on each of these areas, including those areas where the MCO will not pursue a performance improvement project.

c. Clinical Priority Areas:

1) Immunizations;
2) Evaluation of the need for specialty services;
3) Availability and content of comprehensive assessments;
4) Smoking cessation;
5) Enrollees with special health needs;
6) Outpatient management of asthma;
7) Provision of family planning services;
8) STD screening and treatment;
9) High volume/high risk services identified by the MCO;

10) Prevention and care of acute and chronic conditions;
11) Coordination and continuity of care;
12) Obesity.

Non-Clinical Priority Areas:

1) Grievances, appeals and complaints;
2) Access to and availability of services;
3) Enrollee satisfaction with MCO customer service;
4) Satisfaction with services for enrollees with special health care needs;
5) Cultural competency of the MCO and its providers.

In addition, the MCO may be required to conduct performance improvement projects specific to the MCO and to participate in one (1) annual statewide project that may be specified by the Department.

d. The Department's Approved Performance Measures

The Department will evaluate the MCO's performance using the Department's approved performance measures, based on MCO-supplied encounter data and other relevant data (for selected measures). Evaluation of MCO performance on each measure will be conducted on timetables determined by the Department. The technical specifications for each measure are established by the Department with MCO and other stakeholder input.

The Department will inform the MCO of its performance on each measure, whether the MCO's performance satisfied the goal requirements set by the Department, and whether a performance improvement initiative by the MCO is required. The MCO will have 60 business days to review and respond to the Department's performance report. When a performance improvement initiative is required due to sub-goal performance on the measure, the MCO may request recalculation of the performance level based on new or additional data the MCO may supply, or if the MCO can demonstrate material error in the calculation of the performance level. The Department will provide a tentative schedule of measure calculation dates to the MCO within 90 days of the beginning of each calendar year in the contract period.

Unless otherwise noted within a specific performance improvement measure, the Department may specify minimum performance levels and require that the MCO develops a plan to respond to levels below the minimum performance levels. Additions, deletions or modifications to the Performance Improvement Measures must be mutually agreed upon by the

parties. The Department will give 90 days notice to the MCO of its intent to change any of measures, technical specifications or goals. The MCO shall have the opportunity to comment on the measure specifications, goals and implementation plan within the 90-day notice period. The Department reserves the right to require the MCO to report such performance measure data as may be deemed necessary to monitor and improve MCO-specific or program-wide quality performance.

U. Access to Premises

The MCO must allow duly authorized agents or representatives of the state or federal government, access to the MCO's or MCO's subcontractor's premises during normal business hours to inspect, audit, monitor or otherwise evaluate the performance of the MCO's or subcontractor's contractual activities, and shall produce all records requested as part of such review or audit within a reasonable time, but not more than 10 working days. Upon request for such right of access the MCO or subcontractor must provide staff to assist in the audit or inspection effort, and adequate space on the premises to reasonably accommodate the state or federal personnel conducting the audit or inspection effort. All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of MCO's or subcontractor's activities. The MCO will be given 30 business days to respond to any findings of an audit before the Department shall finalize. All information obtained will be accorded confidential treatment as provided under applicable laws, rules or regulations.

V. Subcontracts

The MCO must ensure that all subcontracts shall be in writing, shall comply with the provisions of this contract, and shall include any general requirements of this contract that are appropriate to the service or activity identified in this section, and to ensure that all subcontracts shall not terminate legal liability of the MCO under this contract. The MCO may subcontract for any function covered by this contract, subject to the requirements of this contract.

W. Comply With Applicable Laws

In the provision of services under this agreement, the contractor and its subcontractor shall comply with all applicable federal and state statutes and regulations, and all amendments thereto, that are in effect when the agreement is signed, or that come into effect during the term of the agreement. This includes but is not limited to Title XIX of the Social Security Act and Title 42 of the CFR.

Changes to Medicaid covered services mandated by federal or state law subsequent to the signing of this contract will not affect the contract services for the term of this contract, unless agreed to by mutual consent, or the change is necessary to continue to receive federal funds or due to action of a court of law.

The Department may incorporate into the contract any change in covered services mandated by federal or state law effective the date the law goes into effect, if it adjusts the capitation rate accordingly. The Department will give the MCO at least 30 days notice before the intended effective date of any such change that reflects service increases, and the MCO may elect to accept or reject the service increases for the remainder of that contract year. The Department will give the MCO 60 days notice of any such change that reflects service decreases, with a right of the MCO to dispute the amount of the decrease within that 60 days. The MCO has the right to accept or reject service decreases for the remainder of the contract year. The date of implementation of the change in coverage will coincide with the effective date of the increased or decreased funding. This section does not limit the Department's ability to modify this contract due to changes in the state budget.

The MCO is not endorsed by the federal or state government, CMS, or similar entity.

Federal funds have not been used for lobbying.

X. Use of Medicaid Certified Providers

Except in emergency situations, the MCO must use only providers who have been certified by the Medicaid program for services or items covered by Wisconsin Medicaid. The Department reserves the right to withhold retrospectively from the capitation payments the monies related to services provided by non-Medicaid certified providers, at the Medicaid FFS rate for those services, unless the MCO can demonstrate that it reasonably believed, based on information provided by the Department, that the provider was certified by the Medicaid program at the time the MCO reimbursed the provider for service provision. The Wis. Adm. Code, Chapter HFS 105, contains information regarding provider certification requirements. Every Medicaid MCO must require each physician providing services to enrollees to have a unique physician identifier, as specified in Section 1173(b) of the Social Security Act.

Y. Reproduction and Distribution of Materials

Reproduce and distribute at MCO expense, according to a reasonable Department timetable, information or documents sent to MCO from Department that contain information the MCO-affiliated providers must have in order to fully implement this contract.

Z. Interpreter Services

The MCO must provide interpreter services for enrollees as necessary to ensure availability of effective communication regarding treatment, medical history, health education and/or any other component of this contract. The MCO must:

1. Provide for 24-hour a day, seven (7) day a week access to interpreter services in languages spoken by those individuals eligible to receive the services provided by the MCO or its providers.

2. Provide an interpreter in time to assist adequately with all necessary care, including urgent and emergency care, when an enrollee or provider requests interpreter services in a specific situation where care is needed. The MCO must clearly document all such actions and results. This documentation must be available to the Department upon request.

3. Use professional interpreters as needed, where technical, medical, or treatment information or other matters, where impartiality is critical, are to be discussed, or where use of a family member or friend as interpreter is otherwise inappropriate. Family members, especially children, should not be used as interpreters in assessments, therapy and other situations where impartiality is critical.

4. Maintain a current list of "On Call" interpreters who can provide interpreter services. Provision of interpreter services must be in compliance with Title VI of the Civil Rights Act.

5. Designate a person responsible for the administration of interpreter/ translation services.

6. Receive Department approval of written policies and procedures for the provision of interpreter services. A list of interpreters the MCO uses and the language spoken by each interpreter must be submitted to the Department.

AA. Coordination and Continuation of Care

The MCO must ensure that the care of new enrollees is not disrupted or interrupted. The MCO must ensure continuity of care for new enrollees receiving health care under Medicaid fee-for-service prior to their enrollment in the MCO. The MCO must:

Authorize coverage of services with the enrollee's current providers for the first 60 days of enrollment or until the first of the month following completion of the initial assessment and care plan, whichever is later. If the care plan is not completed within the first 90 days after enrollment, the consumer must be given at least 30 days from the development of the care plan to decide whether to opt out of the MCO. The MCO will be provided with a comprehensive list of the existing FFS providers for each enrollee via the Predictive Model, to enable recruitment of those providers into the managed care provider network. Any HIPAA issues that arise during this process must be addressed. The Enrollment Specialist will obtain provider information from new enrollees whenever possible and share that information with the MCO.

1. The first 60 days will allow the MCO to contact existing providers and to conduct the assessment. If the care plan is not completed within the first 90 days after enrollment, the enrollee has 30 days following notification of the care plan to disenroll.

2. Allow continuation of medications already in use by the enrollee subject to a physician's prescription order. The MCO may consult with the enrollee's physician to determine if transition to a generic medication or therapeutic equivalent will meet the enrollee's needs. The MCO will not deny coverage of a medication already in use unless the prescriber agrees and orders a substitute drug.

3. Systems in place to ensure well-managed patient care, including at a minimum:

    a. Managing and integrating health care through a primary provider, gatekeeper, or other means.

    b. Systems to ensure referrals for medically necessary, specialty, secondary and tertiary care.

    c. Systems to ensure provision of care in emergency situations, including an education process to help assure that enrollees know where and how to obtain medically necessary care in emergency situations.

    d. Systems that clearly specify referral requirements to providers and subcontractors. The MCO must keep copies of referrals (approved and denied) in a central file or the patient's medical records.

    e. Systems to ensure the provision of a clinical determination, of the medical necessity and appropriateness for the enrollee to continue with mental health or substance abuse providers who are not subcontracted by the MCO. The determination must be made within 10 business days of the enrollee's request. If the MCO determines that the enrollee does not need to continue with the non-contracted provider, it must ensure an orderly transition of care.

    f. Have a system in place that coordinates services with those provided for SSI-Medicaid recipients through the Dane County Public Schools.

    g. MCO must have a detailed automated system for collecting information on all enrollee contacts by care coordinators, case managers, and any other staff that has a direct impact on the enrollee's access to services.

h. MCO shall assist members who wish to receive care through another SSI MCO or return to the FFS system by making appropriate referrals and by assisting in the transfer of medical records to new providers.

BB. MCO Cards

The MCO may issue their own MCO ID cards. The MCO may not deny services to an enrollee solely for failure to present the MCO issued ID card. The Medicaid Forward ID card will always determine managed care enrollment, even where the MCO issues a MCO ID card.

CC. Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHC)

If an MCO contracts with a Medicaid certified FQHC or RHC for the provision of services to its enrollees, the MCO must negotiate payment rates for that FQHC or RHC on the same basis it negotiates with other clinics and primary providers. An MCO that contracts with an FQHC or RHC must report to the Department within 45 days of the end of each quarter (for example, January 1 – March 31 reports are due May 15) the total amount paid to each FQHC or RHC per month and as reported on the 1099 forms prepared by the MCO for each FQHC or RHC. FQHC or RHC payments include direct payments to a medical provider who is employed by the FQHC or RHC. The report must be an aggregate of all payments made to contracted FQHCs or RHCs.

DD. Provider Education

The MCO must have written policies to identify and ensure access to providers with experience in serving specific target populations. These policies must also include protocols for training and informing providers in their network in order to promote and develop providers' skills in responding to the needs of persons with mental, developmental and physical disabilities. The training should include clinical and communication issues and the role of the care coordinators.

EE. Coordination with Prenatal Care Agencies, School-Based Services, and Targeted Case Management Services

1. Prenatal Care Coordination (PNCC) Agencies – The MCO must sign an MOU with all agencies in the MCO service area that are Medicaid certified PNCC. The main purpose of the MOU is to ensure coordination of care between the MCO that provides medical services, and the PNCC that provides outreach, risk assessment, care planning, care coordination and follow-up.

   In addition, the MCO must assign the MCO medical representative to interface with the care coordinator from the PNCC. The MCO representative shall work with the care coordinator to identify what

Medicaid-covered services, in conjunction with other identified social services, are to be provided to the enrollee. The MCO is not liable for medical services directed outside of their provider network by the care coordinator unless prior authorized by the MCO. In addition, the MCO is not required to pay for services provided directly by the PNCC provider. The Department pays such services on a FFS basis.

2. School-Based Services (SBS) – The MCO must use its best effort to sign an MOU with all providers in the MCO service area to ensure continuity of care and to avoid duplication of services. SBS are paid FFS by Medicaid when provided by a Medicaid certified SBS provider. However, in situations where an enrollee's course of treatment is interrupted due to school breaks, after school hours or during the summer months, the MCO is responsible for providing and paying for all Medicaid covered services.

   To avoid duplication of services and to promote continuity of care the MCO must sign a Memorandum of Understanding (MOU) with all SBS providers in the MCO service area who are Medicaid certified. For Medicaid certification purposes, a SBS service provider is a school district under Ch. 120, Wis. Stats., or a cooperative educational service agency (CESA) under Ch. 116, Wis. Stats.

3. Targeted Case Management (TCM) Agencies – The MCO must interface with the case manager from the TCM agency to identify what Medicaid-covered services or social services, are to be provided to an enrollee. The MCO is not required to pay for medical services directed outside of their provider network by the case manager unless prior authorized by the MCO. The Department will distribute a statewide list of Medicaid certified TCM agencies to the MCO and periodically update the list.

4. Special Supplemental Food Program for Women, Infants, and Children (WIC) – Section 1902(a)(11)(C) of the Social Security Act requires coordination between the Medicaid MCO and WIC. This coordination includes the referral of potentially eligible women, infants, and children to the WIC program and the provision of medical information by providers working within Medicaid Managed care plans to the WIC program if requested by WIC agencies. Typical types of medical information requested by WIC agencies include information on nutrition related metabolic disease, diabetes, low birth weight, failure to thrive, prematurity, infants of alcoholic, mentally retarded, or drug addicted mothers, AIDS, allergy or intolerance that affects nutritional status, and anemia.

FF. Physician Incentive Plans

A physician incentive plan is any compensation arrangement between the MCO and a physician or physician group that may directly or indirectly have the effect

of reducing or limiting services provided with respect to individuals enrolled with the MCO.

The MCO shall fully comply with the physician incentive plan requirements specified in 42 CFR s. 417.479(d) through (g) and the requirements relating to subcontracts set forth in 42 CFR s. 417.479(i), as those provisions may be amended from time to time.

GG. Advance Directives

The MCO must maintain written policies and procedures related to advance directives (written information provided must reflect changes in state law as soon as possible, but no later than 90 days after the effective date of change). An advance directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under Wisconsin law (whether statutory or recognized by the courts of Wisconsin) and relating to the provision of such care when the individual is incapacitated. The MCO must:

1. Provide written information at time of MCO enrollment to all enrollees, their legal guardians and/or their authorized representatives regarding:

    a. The individual's rights under Wisconsin law (whether statutory or recognized by the courts of Wisconsin) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.

    b. The MCO's written policies respecting the implementation of such rights.

2. Document in the individual's medical records whether or not the individual has executed an advance directive.

3. Shall not discriminate in the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive. This provision shall not be construed as requiring the provision of care that conflicts with an advance directive.

4. Ensure compliance with requirements of Wisconsin law (whether statutory or recognized by the courts of Wisconsin) respecting advance directives.

5. Provide education for staff and the community on issues concerning advance directives.

The above provisions shall not be construed to prohibit the application of any Wisconsin law which allows for an objection on the basis of conscience for any health care provider or any agent of such provider which as a matter of conscience cannot implement an advance directive.

HH. Ineligible Organizations

Upon obtaining information or receiving information from the Department or from another verifiable source, exclude from participation in the MCO all organizations which could be included in any of the following categories (references to the Act in this section refer to the Social Security Act):

1. Entities Which Could Be Excluded Under Section 1128(b)(8) of the Social Security Act-- These are entities in which a person who is an officer, director, agent or managing employee of the entity, or a person who has direct or indirect ownership or control interest of 5% or more in the entity has:

    a. Been convicted of the following crimes:

        1) Program related crimes, (i.e., any criminal offense related to the delivery of an item or service under Medicare or Medicaid [see Section 1128(a)(1) of the Act]); *or*,

        2) Patient abuse, (i.e., criminal offense relating to abuse or neglect of patients in connection with the delivery of health care [see Section 1128(a)(2) of the Act]); *or*,

        3) Fraud, (i.e., a state or federal crime involving fraud, theft, embezzlement, breach of judiciary responsibility, or other financial misconduct in connection with the delivery of health care or involving an act or omission in a program operated by or financed in whole or part by federal, state or local government [see Section 1128(b)(1) of the Act]); *or*,

        4) Obstruction of an investigation, (i.e., conviction under state or federal law of interference or obstruction of any investigation into any criminal offense described in Subsections a, b, or c [see Section 1128(b)(2) of the Act]); or

        5) Offenses relating to controlled substances (i.e., conviction of a state or federal crime relating to the manufacture, distribution, and prescription or dispensing of a controlled substance [see Section 1128(b)(3) of the Act]).

    b. Been Debarred, Suspended or Otherwise Excluded, or is an Affiliate (as defined in such Act) of a person described in Paragraph 4 above, from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to

Executive Order No. 12549 or under guideline implementing such order.

c. Been Assessed a Civil Monetary Penalty under Section 1128A of the Act. Civil monetary penalties can be imposed on individual providers, as well as on provider organizations, agencies, or other entities by the DHHS Office of Inspector General. Section 1128A authorizes their use in case of false or fraudulent submittal of claims for payment, and certain other violations of payment practice standards. (See Section 1128(b)(8)(B)(ii) of the Act.)

2. Entities Which Have a Direct or Indirect Substantial Contractual Relationship-- With an individual or entity. A substantial contractual relationship is defined as one (1) that provides for one (1) or more of the following services:

a. The administration, management, or provision of medical services.

b. The establishment of policies pertaining to the administration, management, or provision of medical services.

c. The provision of operational support for the administration, management, or provision of medical services.

3. Entities Which Employ, Contract With, or Contract Through Any Individual or Entity That is Excluded From Participation in Medicaid under Section 1128 or 1128A, for the Provision (Directly or Indirectly) of Health Care, Utilization Review, Medical Social Work or Administrative Services-- For the services listed, MCO must exclude from contracting any entity which employs, contracts with, or contracts through an entity which has been excluded from participation in Medicaid by the Secretary under the authority of Section 1128 or 1128A of the Act.

MCO attests by signing this contract that it excludes from participation in the MCO all organizations which could be included in any of the above categories.

II. Agreements

The MCO will make available agreements through which the MCO directly provides or contracts for the organizational, administrative and service delivery capabilities to effectively organize and guide operations and meet the contractual obligations, which include, but are not limited to:

1. A policy making body which oversees operations and devotes resources sufficient to effectively plan, organize, administer and evaluate the program's operation.

2. An Executive Director whose duties are described in writing.

3. A Medical Director, available as needed.

4. Sufficient staff and resources to support the project's clinical and administrative activities and responsibilities.

5. Facilities and equipment that meet applicable state requirements.

6. Determinations of medical necessity that are not influenced by financial considerations.

7. A system for informing employees and contract providers about all relevant program requirements, including coverage and appeal procedures.

This contract shall have precedence over any agreement between the MCO and any other entity. Any such agreement shall not dilute the legal responsibility of the MCO under this contract. If there is ever any perceived conflict between any such agreement and this contract, the agreement shall be null and void to the extent of the conflict, and the terms of this agreement shall govern. The MCO certifies by signing this contract that both parties to any such agreement understand and agree.

JJ. Clinical Laboratory Improvement Amendments

When coordinating laboratory services, MCO shall use only laboratories that have a valid Clinical Laboratory Improvement Amendments (CLIA) certificate along with a CLIA identification number. The laboratories must comply with the CLIA regulations as specified by 42 CFR Part 493, "Laboratory Requirements" and provide only the types of tests permitted under the terms of their certification.

KK. Limitation on Fertility Enhancing Drugs

The MCO must get prior authorization from the Chief Medical Officer in the Division of Health Care Financing before the MCO provider treats an enrollee with any of the following drug products: Chorionic Gonadotropin, Clomiphene, Gonadorelin, Menotropins, Urofollitropin and any other new fertility enhancing drugs.

LL. Reporting of Communicable Diseases

As required by ss. 252.05, 252.15(5)(a)6 and 252.17(7)(9b), Wis. Stats., physicians, physician assistants, podiatrists, nurses, nurse midwives, physical therapists, and dietitians affiliated with a Medicaid MCO shall report the appearance, suspicion or diagnosis of a communicable disease or death resulting from a communicable disease to the local health department for any enrollee treated or visited by the provider. Reports of human immunodeficiency virus (HIV) infection shall be made directly to the State Epidemiologist. Such reports shall include the name, sex, age, residence, communicable disease, and any other

facts required by the local health department and Wisconsin Division of Public Health. Such reporting shall be made within 24 hours of learning about the communicable disease or death or as specified in s. HFS 145.04 Wis. Adm. Code and Ch. HFS 145, Appendix A, Wis. Adm. Code. Charts and reporting forms on communicable diseases are available from the local health department. Each laboratory subcontracted or otherwise affiliated with the MCO shall report the identification or suspected identification of any communicable disease listed in Ch. 145, Appendix A, Wis. Adm. Code to the local health department; reports of HIV infections shall be made directly to the State Epidemiologist.

MM. Medicaid MCO Advocate Requirements

The MCO must employ a Medicaid MCO Advocate during the entire contract term. The Medicaid MCO Advocate must work with both enrollees and providers to facilitate the provision of Medicaid benefits to enrollees; is responsible for making recommendations to management on any changes needed to improve either the care provided or the way care is delivered; and must be in an organizational location within the MCO which provides the authority needed to carry out these tasks. The detailed requirements of the Medicaid MCO Advocate are listed below:

1. Functions of the Medicaid MCO Advocate(s):

    a. Investigate and resolve access and/or cultural sensitivity issues identified by MCO staff, state staff, providers, advocate organizations, and/or enrollees.

    b. Monitor formal and informal grievances with the grievance personnel for purposes of identification of trends or specific problem areas of access and/or care delivery. This monitoring function includes ongoing participation in the MCO grievance committee.

    c. Recommend policy and procedural changes to MCO management including those needed to ensure and/or improve enrollee access to quality care. The recommended changes must apply to both internal administrative policies and subcontracted providers.

    d. Act as the primary contact for enrollee advocacy groups. Work with advocacy groups on an ongoing basis to identify and correct enrollee access barriers.

    e. Act as the primary contact for local community-based organizations (local governmental units, non-profit agencies, etc.). Work with the local community-based organizations on an ongoing basis to acquire knowledge and insight regarding the special health care needs of Medicaid enrollees.

f. Participate in the Department's advocacy program for Managed Care. Such participation includes working with DHCF Managed Care staff person assigned to the MCO on issues of access to medical care, quality of medical care, and working with the enrollment specialist, ombudsmen, and the Department's approved external advocate on issues of access to medical care, quality of medical care and enrollment and disenrollment.

g. Ongoing analysis of internal MCO system functions with MCO staff, as these functions may affect enrollee access to quality medical care.

h. Organize and provide ongoing training and educational materials for MCO staff and providers to enhance their understanding of the values and practices of all cultures with which the MCO interacts.

i. Provide ongoing input to MCO management on how changes in the MCO provider network may affect enrollee access to medical care and enrollee quality and continuity of care. Participation in the development and coordination of plans to minimize any potential problems that could be caused by provider network changes.

j. Review and approve all MCO informing material to be distributed to Medicaid enrollees for the purpose of assessing clarity and accuracy.

k. Assist enrollees and their authorized representatives in obtaining medical records.

l. The lead advocate position will be responsible for overall evaluation of the MCO's internal advocacy plan and will be required to monitor any contracts the MCO may enter into for external advocacy with culturally diverse associations or agencies. The lead advocate will be responsible for training the associations or agencies and assuring their input into the MCO's advocacy plan.

2. Staff Requirements and Authority of the Medicaid MCO Advocate(s):

a. At a minimum, one FTE Medicaid MCO Advocate specific to the needs and issues of the SSI/SSI-related enrollees must be located in the organizational structure so that this advocate has the authority to perform the functions and duties listed in Section 1 for this specific population. This advocate shall be in addition to MCO advocates that may already be in place for other enrollees not covered under this contract.

b. The Medicaid MCO advocate is responsible for facilitating and ensuring access to all medically necessary services as stipulated in this contract.

c. The MCO advocate must be knowledgeable and experienced working with disabled persons and shall have adequate time to advocate for the target SSI populations.

d. The MCO certification application requires the MCO to state the staffing levels to perform the functions and duties listed in Section 1 in terms of number of full and part-time staff and total Full Time Equivalents (FTEs) assigned to these tasks. The Department assumes that an MCO acting as an Administrative Service Organization (ASO) for another MCO will have one (1) advocate or FTE position for each ASO contract as well as maintaining their own internal advocate.

The MCO must regularly evaluate the advocate position, workplan, and job duties and allocate an FTE advocate position to meet the duties listed in Section 1a, l if there is significant increase in the MCO's enrollee population or in the MCO service area. The Department reserves the right to require the MCO to employ another advocate position if the MCO does not demonstrate adequacy of one FTE advocate position.

In order to meet the requirement for the advocate position statewide, the DHFS encourages the MCO to contract or have a formal memorandum of understanding for advocacy and/or translation services with associations or organizations that have culturally diverse populations within the MCO service area. However, the overall or lead responsibility for the advocate position will be within each MCO. MCO must monitor the effectiveness of the associations and agencies under contract and may alter the contract(s) with written notification to the Department.

e. The MCO's advocate-staffing levels must be maintained and solely devoted to the functions and duties listed in Section 1 throughout the contract. The Department must approve changes in the Medicaid MCO advocate staffing levels at least 30 days prior to the effective date of the change.

f. Prior to contract signing the MCO advocate must develop a Medicaid MCO workplan, with the timelines and activities specified, and must maintain and modify it as necessary, throughout the contract term.

NN. MCO Designation of Staff Person As Contract Representative

The MCO is required to designate a staff person to act as liaison to the Department for all issues that relate to the contract between the Department and the MCO. The contract representative will be authorized to represent the MCO regarding inquiries pertaining to the contract, will be available during normal business hours, and will have decision making authority in regard to urgent situations that arise. The contract representative will be responsible for follow-up on contract inquiries initiated by the Department.

OO. Subcontracts with Local Health Department

The Department encourages the MCO to contract with Local Health Departments (LHD) for the provision of care to Medicaid recipients in order to assure continuity and culturally appropriate care and services. LHDs can provide HealthCheck outreach and screening, immunizations, and services to targeted populations within the community for the prevention, investigation, and control of communicable diseases (e.g., tuberculosis, HIV/AIDS, sexually transmitted diseases, hepatitis and others). WIC projects provide nutrition services and supplemental foods, breastfeeding promotion and support; and immunization screening. Many projects screen for blood lead poisoning during the WIC appointment.

The Department encourages the MCO to work closely with LHD. The LHD has a wide variety of resources that can be coordinated with the MCO to produce more efficient and cost effective care for MCO enrollees. Examples of such resources are ongoing programs of medical services, materials on health education, prevention, and disease states, expertise on outreaching specific sub-populations, communication networks with varieties of medical providers, advocates, community-based health organizations, and social service agencies, and access to ongoing studies of and information about health status and disease trends and patterns.

PP. Subcontracts with Community-Based Health Organizations

The Department encourages the MCO to contract with community-based health organizations for the provision of care to Medicaid recipients in order to assure continuity and culturally appropriate care and services. Community-based organizations can provide HealthCheck outreach and screening, immunizations, family-planning services, and other types of services.

The Department encourages the MCO to work closely with community-based health organizations. Community-based health organizations may also provide services, such as WIC services, that the MCO is required by federal law to coordinate with and refer to, as appropriate.

QQ. Prescription Drugs

When an enrollee elects to use a family planning provider that is not MCO affiliated, the MCO is liable for the cost of all medically necessary drugs when ordered by a certified Medicaid family planning provider and filled by an MCO network provider.

Pharmacy services for enrollees dually eligible for Medicaid and Medicare are not covered by the MCO.

RR. MCO Attestation

The Chief Executive Officer (CEO), the Chief Financial Officer (CFO) or designee must attest to the best of their knowledge to the truthfulness, accuracy, and completeness of all data submitted to the Department at the time of submission. This includes encounter data, AIDS/Vent, Sterilization Reports or any other data in which the MCO paid claims.

SS. Fraud and Abuse Investigations

1. MCO agrees to cooperate with the Department on fraud and abuse investigations. In addition, the MCO agrees to report allegations of fraud and abuse (both provider and enrollee) to the Department within 15 days of the suspected fraud or abuse coming to the attention of the MCO. Failure on the part of the MCO to cooperate or report fraud and/or abuse may result in any applicable sanctions under the contract.

2. MCO agrees to establish and maintain administrative and management arrangements or procedures, including a mandatory compliance plan, designed to guard against fraud and abuse. The arrangements or procedures must include the following:

    a. Written policies, procedures, and standards of conduct that articulate the MCO's commitment to comply with all applicable federal and state standards.

    b. The designation of a compliance officer and a compliance committee that are accountable to senior management.

    c. Effective training and education for the compliance officer and the organization's employees.

    d. Effective lines of communication between the compliance officer and the organization's employees.

    e. Enforcement of standards through well-publicized disciplinary guidelines.

f. Provision for internal monitoring and auditing.

g. Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the MCO contract.

ARTICLE IV

IV. FUNCTIONS AND DUTIES OF THE DEPARTMENT

In consideration of the functions and duties of the MCO contained in this contract, the Department shall:

A. Eligibility Determination

Identify and send informing materials to Medicaid recipients who meet the covered population criteria in this Article with the following medical status codes:

Medical Status Code	Description
01	SSI; Aged; Not in nursing home
04	SSI Aged; Decline cash; not in nursing home
05	SSI Aged; Med-Ndy; No cash; not in nursing home
10	County 503 Cases; SSI ineligible ABD-disregard SSA-CLA
11	SSI; Blind; Not in nursing home
14	SSI Blind; Decline cash; not in nursing home
15	SSI Blind; Med-Ndy; Not in nursing home
19	SSI; Employed
20	SSI; Essential; Spouse of disabled person; No$
21	SSI; Disabled; Not in nursing home
22	SSI Disabled; Decline cash; not in nursing home
23	SSI Disabled; Med-Ndy
AD	County Aged; Med-Ndy; Deductible; SSI >65 income >185% FPL
BD	County Blind; Med-Ndy; Deductible; SSI >65 income >185% FPL
DC	County Disabled; SSI Inelig; Due to SSA-CLA disabled adult children living with parents
DD	County Disabled; Med-Ndy; Deductible; SSI >185% income FPL
L1	County Widow(ers); SSI ineligible due to increase disability benefits early receipt of Social Security
L3	County Widow/(ers); SSI ineligible due to increase disability benefits early receipt of Social Security
L5	County Widow/(ers); SSI ineligible due to increase disability benefits early receipt of Social Security
L7	County Widow/(ers); SSI ineligible due to increase disability benefits early receipt of Social Security
M3	MAPP, >150% (FPL)
M4	MAPP, to 150% (FPL) no premium
ZZ	SSI Zebley Decision
5C	County 503 Case; Recipient Med-Ndy
5D	Disabled Adult/Child Med-Ndy

* See Actuarial Basis, for overview of capitation rate determination. For MCO-specific capitation rate, see Service Coverage/Payment.

B. Enrollment

Promptly notify the MCO of all Medicaid recipients enrolled in the MCO under this contract. Notification shall be effected through the MCO Enrollment Reports. All recipients listed as an ADD/NEW, ADD/RS or CONTINUE on either the Initial or Final MCO Enrollment Report are members of the MCO during the enrollment month. The reports shall be generated in the sequence specified under MCO Enrollment Reports. These reports shall be in both tape and hard copy formats or available through electronic file transfer capability and shall include Medical Status Codes.

C. Disenrollment

Promptly notify the MCO of all Medicaid recipients no longer eligible to receive services through the MCO under this contract. Notification shall be effected through the MCO Enrollment Reports, which the Department will transmit to the MCO for each month of coverage throughout the term of the contract. The reports shall be generated in the sequence. Any recipient who was enrolled in the MCO in the previous enrollment month, but does not appear as an ADD/NEW, ADD/RS or CONTINUE on either the Initial or Final MCO Enrollment report for the current enrollment month, is disenrolled from the MCO effective the last day of the previous enrollment month.

D. Reports

1. MCO Enrollment Reports

   For each month of coverage throughout the term of the contract, the Department shall transmit "MCO Enrollment Reports" to the MCO. These reports will provide the MCO with ongoing information about its Medicaid enrollees and disenrollees and will be used as the basis for the monthly capitation claims. The MCO Enrollment Reports will be generated in the following sequence:

   a. The Initial MCO Enrollment Report will list all of the MCO's enrollees and disenrollees for the enrollment month that are known on the date of report generation. The Initial MCO Enrollment Report will be available to the MCO on or about the twenty-first of each month. A capitation claim shall be generated for each recipient listed as an ADD/NEW, ADD/RS or CONTINUE on this report. Recipients who appear as PENDING on the Initial MCO Enrollment Report and are reinstated into the MCO prior to the end of the month will appear as a CONTINUE on the Final MCO Enrollment Report, and a capitation claim shall be generated at that time.

   b. The Final MCO Enrollment Report will list all of the MCO's enrollees and disenrollees for the enrollment month that were not

included in the Initial MCO Enrollment Report. The Final MCO Enrollment Report will be available to the MCO by the first day of the capitation month. A capitation claim shall be generated for each recipient listed as an ADD/NEW, ADD/RS or CONTINUE on this report. PENDING status will not be included on the Final MCO Enrollment Report.

c. The Department shall provide the MCO with effective dates for medical status code changes, county changes and other address changes in each enrollment report to the extent that the county reports these to the Department, and Medicare start date, when applicable.

2. Coordination of Benefits Extract Report

This report will provide the MCO with a monthly extract listing of Medicaid enrollees covered under this contract who have Medicare or other insurance coverage with no end date or with an end date that falls within 12 months prior to the current reporting month. The first report to the MCO will be a comprehensive listing of enrollees in the MCO. Subsequent reports will identify changes, including new enrollees and their Medicare and other insurance information.

E. Utilization Review And Control

Waive, to the extent allowed by law, any present Department requirements for prior authorization, second opinions, co-payment, or other Medicaid restrictions for the provision of contract services provided by the MCO to enrollees, except as may be provided.

F. MCO Review

1. Materials Distributed to Medicaid Recipients

Submit to the MCO, for review, materials that describe the specific MCO and that will be distributed by the Department or County to recipients.

2. MCO Review of Study or Audit Results

Submit to the MCO, for a 30-business day review/comment period, any studies or audits that are going that are to be released to the public that are about the MCO and Medicaid.

G. Handbooks

Provide the MCO with appropriate handbooks and bulletins.

H. Vaccines

Provide certain vaccines to MCO providers for administration to Medicaid MCO enrollees according to the policies and procedures in the Wisconsin Medicaid and BadgerCare Physician Services Handbook. The Department will reimburse the MCO for the cost of vaccines that are newly approved during the contract year and not yet part of the Vaccine for Children program. The cost of the vaccine shall be the same as the cost to the Department of buying the new vaccine through the Vaccine for Children program. The MCO retains liability for the cost of administering the vaccines.

I. Coordination of Benefits

Maintain a report of recovered monies reported by the MCO and its subcontractors.

J. Wisconsin Medicaid Provider Reports

Provide a monthly electronic listing of all Wisconsin Medicaid certified providers to include, at a minimum, the name, address, Wisconsin Medicaid provider ID number, and dates of certification in Wisconsin Medicaid.

K. Enrollee Health Status and Primary Language Report

The Department will provide the MCO with an enrollee health status and primary language report of all enrollees who have agreed to participate with the gathering of this data. The reports will be provided to the MCO on a monthly basis. The purpose of this report is to assist the MCO with continuity of care issues and to assist with the identification of non-English speaking enrollees and to facilitate appointments for enrollees who have urgent health care needs.

L. Fraud and Abuse Training

The Department will provide fraud and abuse detection training to the MCO annually.

M. Provision of Data to the MCO

Provide to the MCO immunization information from the Wisconsin immunization registry to the extent available. The Department will make every effort to get the Wisconsin Immunization Registry information to the MCO.

ARTICLE V

V. PAYMENT TO THE MCO

A. Capitation Rates

In consideration of full compliance by the MCO with contract requirements, the Department agrees to pay the MCO monthly payments based on the capitation rates. The capitation rates shall be concurrent and based on an actuarially sound methodology as required by federal regulations. The capitation rate shall not include any amount for recoupment of losses incurred by the MCO under previous contracts nor does it include services that are not covered under the State Plan.

Caseload Mix Adjustment: The Department will conduct an analysis comparing actual MCO enrollees diagnosis and service usage intensity (utilization and costs) with the comparable fee-for-service-equivalent population using the Chronic Illness and Disability Payment System (CDPS).

B. Actuarial Basis

The capitation rate is calculated on an actuarial basis recognizing the payment limits set forth in 42 CFR 447.361.

C. Stop-Loss Insurance Option For Inpatient Hospital Services

The Department may insure the MCO for inpatient hospital services provided by the MCO in the following manner:

1. Definitions

   a. "Inpatient Hospital Expenses" – Expenses incurred by a general hospital, psychiatric hospital, or alcohol rehabilitation hospital for contract services.

   b. "Attachment Amount" – The amount of inpatient hospital expenses above which the Department pays. (NOTE: If stop-loss insurance is chosen, the capitation payments to the MCO will be adjusted through manual recoupments made on a monthly basis outside of the normal capitation claim process.)

   At the request of the MCO, the Department will contract for calculation of "Attachment Amounts" for the duration of this contract. The Department will inform the MCO of the estimated cost of developing the attachment amount prior to initiating the process.

The Department will be responsible for the cost of calculating attachment amount if the MCO subsequently elects stop-loss insurance coverage through the Department.

The MCO will be charged for the cost of calculating attachment amount if it subsequently declines stop-loss insurance coverage through the Department.

The Department and the MCO that elects to participate in the Department's stop-loss insurance program for the duration of this agreement will enter into a contract amendment to reflect this decision.

2. Payment

The Department shall pay the MCO 85% of the lesser of inpatient hospital charges or the MCO contracted rate for costs over the attachment amount for services that are covered by the Medicaid program, except that professional fees are not covered under the stop-loss insurance program.

3. Spillover Claims – (Hospital stays continuing into the next calendar year.)

a. When the Department is liable for a stop-loss insurance payment in the above contract year, the Department's stop-loss insurance liability for that hospital stay continues into the next year, if the MCO has continued to receive stop-loss insurance from the Department, until the first appropriate hospital discharge. However, if the MCO's attachment amount changes in the next contract year, the MCO must meet the increased attachment amount before Department liability for that next year's costs begins.

b. Department stop-loss insurance liability for subsequent inpatient hospital stays in that next year will exist only after the new attachment amount is again met in full.

4. Reimbursement

In order to obtain reimbursement from the Department under this stop-loss insurance arrangement, the MCO must submit:

a. A signed affidavit providing the following information:

1) Where the inpatient hospitalization(s) occurred.

2) Dates of service for which charges were paid.

3) Total actual inpatient hospital charges and total charges paid by the MCO.

4) Identifying number and date of check(s) and remittance statement(s) associated with all MCO payments to hospital.

5) Indication of whether or not coordination of benefits with a third party was available on all or part of the stop-loss insurance claims.

b. A hospital-generated Medicaid claim form, either paper or electronic Medicaid UB-92 format (the electronic format used must be approved by the Department), and/or itemized billing for each inpatient hospitalization in the stop-loss insurance claim. Claim forms/billings must identify admission and discharge dates, and indicate diagnosis; and

c. Where coordination of benefits or subrogation is present, an Explanation of Benefits indicating liable persons or organizations, amount(s) charged, and amount(s) received.

5. Payment for Capitated Arrangements

Sections C.2. through C.4. of this Article apply to stop-loss insurance claims on which the MCO has exceeded the attachment amount through FFS payments alone. Where the MCO has a capitation arrangement with one (1) or more of the hospitals involved in a stop-loss insurance claim, the Department will calculate when the attachment is reached and pay for inpatient hospitalization expenses above the attachment amount based on the procedures described in Sections 2. and 3., above. In order to obtain reimbursement from the Department for stop-loss insurance claims involving capitation payments, the MCO must submit:

a. All information required in Section 4.a. through 4.c., above.

b. A copy of those MCO-hospital subcontracts specifying the capitation arrangements applicable to the stop-loss insurance claim.

6. COB Collections

The MCO is responsible for the collection of all COB (coordination of benefits) available on stop-loss insurance claims. No Departmental reimbursement under the stop-loss insurance agreement will be made on claims for which insurance is already available unless an Explanation of (insurance) Benefits is provided indicating how much the insurance paid.

7. Provider Payment Responsibility

   The Department shall not assume responsibility for payment to hospitals for services where the attachment amount has been surpassed, but said responsibility shall be retained by the MCO in all cases.

8. Billing Limitations

   a. The MCO may not bill for stop-loss insurance more frequently than once every 30 days.

   b. The Department shall not pay claims for reimbursement under this section which are submitted more than one (1) year after the end of the calendar year in which the service was provided. Stop-loss insurance claims based on inpatient hospital charges incurred in the prior calendar year must be submitted so that payment can be processed before the end of that calendar year.

9. Reimbursement Timeline

   The Department shall pay claims under this section within 60 days of submission of complete information. If information is incomplete, the Department must notify the MCO within 30 days.

D. Reinsurance

The MCO may obtain a risk-sharing arrangement from an insurer other than the Department for coverage of enrollees under this contract, provided that the MCO remains substantially at risk for providing services under this contract.

E. Payment Schedule

Payment to the MCO shall be based on the MCO Enrollment Reports, which the Department will transmit to the MCO. Payment for each person listed as an ADD or CONTINUE on the MCO Enrollment Reports shall be made by the Department within 60 days of the date the report is generated. Any claim that is not paid within these time limits shall be denied by the Department and the recipient shall be disenrolled from the MCO for the capitation month specified on the claim. Notification of all paid and denied claims shall be given through the weekly Remittance Status Report, which is available on both tape and hard copy.

F. Coordination of Benefits (COB)

The MCO must actively pursue, collect and retain any monies from all available resources for services to enrollees covered under this contract except where the amount of reimbursement the MCO can reasonably expect to receive is less than the estimated cost of recovery (this exception does not apply to collections for AIDS and ventilator dependent patients), or except as provided in Subsection 2.

COB recoveries will only be done by post-payment billing (pay and chase) for certain prenatal care and preventive pediatric services. Post-payment billing will also be done in situations where the third party liability is derived from a parent whose obligation to pay is being enforced by the State Child Support Enforcement Agency and the provider has not received payment within 30 days after the date of service:

1. Cost effectiveness of recovery is determined by, but not limited to time, effort, and capital outlay required to perform the activity. The MCO must be able to specify the threshold amount or other guidelines used in determining whether to seek reimbursement from a liable third party; or, upon request of the Department, describe the process by which the MCO determines seeking reimbursement would not be cost effective.

2. To assure compliance, records shall be maintained by the MCO of all COB collections. Reports shall be made quarterly on the form designated by the Department. The MCO must be able to demonstrate that appropriate collection efforts and appropriate recovery actions were pursued. The Department has the right to review all billing histories and other data related to COB activities for enrollees. The MCO must seek information on other available resources from all enrollees. The MCO must also seek to coordinate benefits before claiming reimbursement from the Department for the AIDS and Ventilator Dependent enrollees:

    a. Other available resources may include, but are not limited to, all other state or federal medical care programs which are primary to Medicaid, group or individual health insurance, ERISAs, service benefit plans, the insurance of absent parents who may have insurance to pay medical care for spouses or minor enrollees, and subrogation/workers compensation collections.

    b. Subrogation collections are any recoverable amounts arising out of settlement of personal injury, medical malpractice, product liability, or Worker's Compensation. State subrogation rights have been extended to the MCO under s. 49.65(9), Act 31, Laws of 1989. After attorneys' fees and expenses have been paid, the MCO shall collect the full amount paid on behalf of the enrollee.

3. Section 1912(b) of the Social Security Act must be construed in a beneficiary-specific manner. The purpose of the distribution provision is to permit the beneficiary to retain TPL benefits he or she has entitlement to except to the extent that Medicaid (or the MCO on behalf of Medicaid) is reimbursed for its costs. The MCO is free, within the constraints of state law and this contract, to make whatever case it can to recover the costs it incurred on behalf of its enrollee. It can use the Medicaid fee schedule, an estimate of what a capitated physician would charge on a fee for service basis, the value of the care provided in the market place or some other acceptable proxy. However, any excess recovery over and

above the cost of care (however, the MCO chooses to define that cost) must be returned to the beneficiary. MCO may not collect from amounts allotted to the beneficiary in a judgment or court-approved settlement. The MCO is to follow the practices outlined in the DHFS Casualty Recovery Manual.

4. Where the MCO has entered into a stop-loss insurance arrangement with the Department, the COB collection and distribution shall follow the procedures described in this contract. Act 27, Laws of 1995 extended assignment rights to the MCO under s. 632.72.

5. COB collections are the responsibility of the MCO or its subcontractors. Subcontractors must report COB information to the MCO. MCO and subcontractors shall not pursue collection from the enrollee but directly from the third party payer. Access to medical services will not be restricted due to COB collection.

6. The following requirement shall apply if the Contractor (or the Contractor's parent firm and/or any subdivision or subsidiary of either the Contractor's parent firm or of the Contractor) is a health care insurer (including, but not limited to, a group health insurer and/or health maintenance organization) licensed by the Wisconsin Office of the Insurance Commissioner and/or a third-party administrator for a group or individual health insurer(s), health maintenance organization(s), and/or employer self-insurer health plan(s):

    a. Throughout the contract term, these insurers and third-party administrators shall comply in full with the provision of Subsection 49.475 of the Wis. Stats. Such compliance shall include the routine provision of information to the Department in a manner and electronic format prescribed by the Department and based on a monthly schedule established by the Department. The type of information provided shall be consistent with the Department's written specifications.

    b. Throughout the contract term, these insurers and third-party administrators shall also accept and properly process post-payment billings from the Department's fiscal agent for health care services and items received by Wisconsin Medicaid recipients.

7. If, at any time during the contract term, any of the insurers or third party administrators fail, in whole or in part, the Department may take the remedial measures specified in this contract.

G. Recoupments

The Department will not normally recoup MCO per capita payments when the MCO actually provided service. However, in situations where the Medicaid recipient cannot use MCO facilities the Department will recoup MCO capitation payments. Such situations are described more fully below:

1. The Department will recoup MCO capitation payments for the following situations where an enrollee's MCO status has changed before the first day of a month for which a capitation payment has been made:

   a. Enrollee moves out of the MCO's service area.

   b. Enrollee enters a public institution.

   c. Enrollee dies.

2. The Department will recoup the MCO capitation payments for situations where the Department initiates a change in an enrollee's MCO status on a retroactive basis, reflecting the fact that the MCO was not able to provide services. For the correction of computer or human error, where the person was never really enrolled in the MCO, recoupments for multiple month's capitation payments are more likely.

3. If the MCO enrollee moves out of the MCO service area, the enrollee will be disenrolled from the MCO on the date the enrollee moved as verified by the eligibility worker. If the eligibility worker is unable to verify the enrollee's move, the MCO must mail a "certified return receipt requested" letter to the enrollee to verify the move. The enrollee must sign for the letter. A copy of the letter and the signed return receipt must be sent to the Department or its designee within 20 days of the enrollees' signature date. If this criteria is met, the effective date of the disenrollment is the first of the month in which the returned registered receipt requested letter was sent. Documentation that fails to meet the 20-day criteria will result in disenrollment the first of the month in which the MCO supplied information to the Department or its designee. Any capitation payment made for periods of time after disenrollment will be recouped.

4. If a contract is terminated, recoupments will be handled through a payment by the MCO within 30 business days of contract termination.

5. If the MCO is unable to meet the HealthCheck requirements.

H. Payment for AIDS/HIV and Ventilator Dependent Enrollees

1. The Department will pay 100% of the MCO's costs of providing Medicaid-covered services to MCO enrollees who meet the AIDS, HIV-positive or ventilator dependent criteria. The MCO may seek reimbursement as specified:

   a. AIDS

      For those enrollees with a confirmed diagnosis of AIDS, as indicated by an ICD-9-CM diagnosis code, the 100% reimbursement is effective on the first day of the month in which they were diagnosed as having AIDS.

   b. HIV-Positive

      For those enrollees who are HIV-Positive and on anti-retroviral drug treatment approved by the Food and Drug Administration, qualify for reimbursement. The 100% reimbursement is effective on the first day of the month that the first anti-retroviral medication was dispensed. If the name of the anti-retroviral medication and the date it was started is unclear, the Department will use the MCO's pharmacy detail record(s) to determine the effective date of enhanced funding.

   c. Ventilator Dependent

      For the purposes of this reimbursement, a ventilator-assisted patient must have died while on total respiratory support or the patient must require equipment that provides total respiratory support. This equipment may be a volume ventilator, a negative pressure ventilator, a continuous positive airway pressure (CPAP) system, or a Bi (inspiratory and expiratory) PAP. The patient may need a combination of these systems. Any equipment used only for the treatment of sleep apnea does not qualify as total respiratory support.

      The reimbursement is available for enrollees meeting the following criteria:

      - The enrollee had an inpatient hospital stay with one of the following qualifying LTC-DRG codes:

        – 0475 – Respiratory system diagnosis with ventilator support.

        – 0482 or 541 – Trachestomy with mouth, face and neck diagnosis.

- 0483 or 542 – Trachestomy with mechanical ventilation 96+ hours except face, neck and mouth diagnosis.

- The qualifying hospital stay was for a minimum of four (4) days or a lesser length, if the enrollee died within the first three (3) days of hospitalization.

The period of enhanced funding starts on the first day of the month that qualifying hospital stay begins and ends on the last day of the month that the hospital stay ends.

2. Adjustments that will be made to the MCO's final payment include, but are not limited to:

   a. Reimbursement(s) already paid to the MCO in the form of capitation payments for enrollees who qualify as being AIDS, HIV-positive or ventilator dependent will be deducted from the MCO's 100% reimbursement.

   b. Costs for care provided to AIDS, HIV-positive or ventilator dependent enrollees who are retroactively disenrolled under this contract, are not payable. The MCO must back out of the cost of care provided during the backdated period from their reports.

3. Reporting Requirements for AIDS, HIV-Positive and Ventilator Dependent Enrollees

   a. MCO must submit detail reports on disk and hard copy and in the format specified in Addendum II.

   b. MCO must submit reports on a quarterly basis (refer to Addendum II).

   c. As required by the Wis. Adm. Code HFS 106.03, payment data or adjustment data must be received by the Department's fiscal agent within 365 days after the date of the service. If the MCO cannot meet this requirement, the MCO must provide documentation that substantiates the delay. The Department will make the final determination to pay or deny the services. The Department will exercise reasonable discretion in making the determination to waive the 365-day billing requirement.

4. Documentation Requirements for AIDS, HIV-Positive and Ventilator Dependent Enrollees

   To qualify enrollees for the reimbursement the MCO must submit the documentation that is required for each policy at the same time as the

quarterly reports. MCO may use the Department's designated form or develop their own as long as it contains the required information as specified for each policy:

a. AIDS Documentation

A signed statement from a physician that indicates a confirmed diagnosis of AIDS, and the diagnosis date must accompany each new request.

b. HIV-Positive Documentation

A signed statement from the physician that the enrollee is HIV-positive and on anti-retroviral medications, the name of the drug and the date it was started must accompany each new request.

c. Ventilator Dependent Documentation

Submission of a copy of the UB 92 or a copy of equivalent UB 92 data with a qualifying LTC-DRG code.

5. Dispute Resolution

Disputes regarding the Department's payment or nonpayment of AIDS, HIV-positive or ventilator dependent Medicaid services must be submitted to the Department in the next report period.

6. Adjustments made by the MCO (e.g. adjustments to provider payments or adjustments due to amounts recovered from third parties) must be submitted with the next report period.

ARTICLE VI

VI. COMPUTER DATA REPORTING SYSTEM DATA RECORDS AND REPORTS

A. Access to and/or Disclosure of Financial Records

The MCO and any subcontractors shall make available to the Department, the Department's authorized agents, and appropriate representatives of the U.S. Department of Health and Human Services any financial records of the MCO or subcontractors which relate to the MCO's capacity to bear the risk of potential financial losses, or to the services performed and amounts paid or payable under this contract. The MCO shall comply with applicable record keeping requirements specified in HFS 105.02(1)-(7) Wis. Adm. Code, as amended.

B. Periodic Reports

The MCO agrees to furnish within the Department's time frame and within the Department's stated form and format, information and/or data from its records to the Department and to the Department's authorized agents, which the Department may require to administer this contract, including but not limited to the following:

1. Quarterly Coordination of Benefits Reports. Summaries of amounts recovered from third parties for services rendered to enrollees under this contract in the format specified.

2. An encounter record for each service provided to enrollees covered by this contract. The Encounter Data set will include at least those data elements specified. The Department will work with the MCO to develop a mechanism for sharing MCO specific data and blinded data from other MCOs in order for the MCO to perform their own independent analysis of the data.

   The encounter data set must be submitted monthly via electronic media.

3. Copies of all formal grievances and documentation of actions taken on each grievance, as specified.

4. Dental quarterly progress reports.

5. Quarterly report of AIDS, HIV-positive, and ventilator dependent information as described

6. Quarterly Federally Qualified Health Centers and Rural Health Centers report.

7. Annual Performance Improvement Studies.

8. Service Enhancements – MCO agrees to identify and support service enhancements, which improve quality of care for persons with disabilities funded from excessive profits realized by the MCO. MCO must document how these funds are used and make documentation available to the Department upon request.

9. Comprehensive Assessment Report, refer to Article III, F., 1.

10. Plan of Care Report.

C. Access to and Audit of Contract Records

Throughout the duration of the contract, and for a period of five (5) years after termination of the contract, the MCO shall provide duly authorized representatives of the state or federal government access to all records and

material relating to the Contractor's provision of and reimbursement for activities contemplated under the contract. Such access shall include the right to inspect, audit and reproduce all such records and material and to verify reports furnished in compliance with the provisions of the contract. All information so obtained will be accorded confidential treatment as provided under applicable law, rules, or regulations.

D. Records Retention

The MCO shall retain, preserve and make available upon request all records relating to the performance of its obligations under the contract, including claim forms, paper and electronic, for a period of not less than five (5) years from the date of termination of the contract. Records involving matters, which are the subject of litigation, shall be retained for a period of not less than five (5) years following the termination of litigation. Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of the Department, provided that the microfilming procedures are approved by the Department as reliable and are supported by an effective retrieval system.

Upon expiration of the five (5) year retention period, the subject records shall, upon request, be transferred to the Department's possession. No records shall be destroyed or otherwise disposed of without the prior written consent of the Department.

E. Special Reporting and Compliance Requirements

The MCO shall comply with the following state and federal reporting and compliance requirements for the services listed below, for the entire MCO, aggregating all service areas if the MCO has more than one (1) service area:

1. Abortions shall comply with the requirements of s. 20.927, Wis. Stats., and with 42 CFR 441 Subpart E--Abortions.

2. Hysterectomies and sterilizations shall comply with 42 CFR 441 Subpart F--Sterilizations.

   Sanctions in the amount of $10,000 may be imposed for non-compliance with the above special reporting and compliance requirements.

3. The MCO shall comply with s. 609.30 Wis. Stats.

F. Reporting of Corporate and Other Changes

The MCO must report to the Department any change in corporate structure or any other change in information previously reported. The MCO must report the change as soon as possible, but not later than 30 days after the effective date of

the change. Changes in information covered under this section include all of the following:

1. Any change in information previously provided by the MCO in response to questions posed by the Department in the current MCO Certification Application or any previous RFB for Medicaid MCO Contracts. This includes any change in information originally provided by the MCO as a "new MCO," within the meaning of the MCO Certification Application or RFB.

2. Any change in information relevant to ineligible organizations.

3. Any change in information relevant to ownership and business transactions of the MCO.

G. Computer/Data Reporting System

The MCO must maintain a computer/data reporting system that complies with all of the reporting requirements established by the Department and for assuring the accuracy and completeness of the data as well as the timely submission of the data. Records available to the Department or its designee must support the data submitted. The Department reserves the right to conduct on-site inspections and/or audits prior to awarding the contract. The MCO must have a contact person responsible for the computer/data reporting system and in a position to answer questions from the Department and resolve problems identified by the Department in regard to the requirements listed below:

1. The MCO must have a claims processing system that is adequate to meet all claims processing and retrieval requirements specified.

2. The MCO must have a computer/data collection, processing, and reporting system sufficient to monitor MCO enrollment/disenrollment (in order to determine on any specific day which recipients are enrolled or disenrolled from the MCO) and to monitor service utilization for the UM requirements of QAPI that are specified in this contract.

3. The MCO must have a computer/data collection, processing, and reporting system sufficient to support the QAPI requirements. The system must be able to support the variety of QAPI monitoring and evaluation activities, including the identification of subpopulations of persons with special health care needs; monitoring/evaluation of quality of clinical care and service; periodic evaluation of MCO providers; member feedback on QAPI; maintenance of and use of medical records in QAPI and monitoring; and evaluation for annual QAPI study topics.

4. The MCO must have a computer and data processing system sufficient to accurately produce the data, reports, and encounter data set in the formats and time lines prescribed by the Department, that are defined in the

contract. The MCO is required to submit electronic test data files as required by the Department in the format referenced in this contract and as specified by the Department. The electronic test data files are subject to Department review and approval before production data is accepted by the Department. Production claims or other documented encounter data must be used for this test data file.

5. The MCO must capture and maintain a patient-level record of each service provided to enrollees using HCFA 1500, UB92, NCPDP, HIPAA code sets or other claim or claim formats that are adequate to meet all reporting requirements in this contract. The computerized database must be a complete and accurate representation of all services covered by the MCO, by all providers rendering services for the MCO including subcontracted vendors for the contract period. The MCO is responsible for monitoring the integrity of the database and facilitating its appropriate use for such required reports as encounter data, and targeted performance improvement studies.

6. The MCO must have a computer processing and reporting system that is capable of following or tracing an encounter within its system using a unique encounter record identification number for each encounter.

7. The MCO reporting system must have the ability to identify all denied claim/encounters using national HIPAA Claim Adjustment Reason.

8. The MCO system must be capable of reporting original and reversed claim detail records or encounters.

9. The MCO system must be capable of correcting an error to the encounter record within 90 days of notification by the Department.

10. The MCO must notify the Department of all significant changes to the system that may impact the integrity of the data, including such changes as new claims processing software, new claims processing vendors and significant changes in personnel.

ARTICLE VII

VII. ENROLLMENT AND DISENROLLMENT

A. Covered Population

Medicaid eligible individuals living in Dane County, age 19 and older, who meet the SSI and SSI related disability criteria in HFS 103.03(1)(c), and are not living in an institution, nursing home, do not have the diagnosis of mental retardation or are participating in a Home and Community-Based (HCBW) Waiver Program

may enroll in the MCO. Individuals dually eligible for Medicare and Medicaid may also enroll in the MCO.

B. Enrollment

1. The MCO shall accept as enrolled all persons who appear as enrollees on the MCO enrollment reports. Eligible individuals will be given six (6) weeks to choose between Medicaid fee-for-service and managed care. If they do not choose, they will be enrolled into managed care.

   a. *Enrollee Lock-In Period* – After enrollment into managed care, the enrollee, a legal guardian, or an authorized representative may request disenrollment without cause at anytime during the first 90 days of enrollment. After the 90-day opt out period, if the enrollee does not choose to go back to fee-for-service, they will be locked into managed care for nine (9) additional months. If the MCO fails to complete the assessment and care plan during the first 90-days of enrollment, the disenrollment period will be extended for 30 days following completion of the assessment and care plan.

   b. *Enrollment Levels* – The MCO must designate its maximum enrollment level for its service area. The Department may take up to 60 days from the date of written notification to implement maximum enrollment level changes. The MCO must accept as enrolled all persons who appear as enrollees on the MCO Enrollment Reports up to the MCO specified enrollment level for the service area. The number of enrollees may exceed the maximum enrollment level by 5% on a temporary basis. The Department does not guarantee any minimum enrollment level. The maximum enrollment level for a service area may be increased or decreased during the course of the contract period based on mutual acceptance of a different enrollment maximum level.

   c. *Additional Health-Related Services* – The MCO must not obtain enrollment through the offer of any compensation, reward, or benefit to the enrollee except for additional health-related services that have been approved by the Department.

2. County Waiver Case Management Services

   A person otherwise eligible for enrollment into the MCO cannot enroll if already participating in:

   a. A Community Integration Program (CIP); or

   b. A Community Options Program (COP); or

   c. Dane County Family Care (FC); or

d. PACE or Partnership Program

3. Enrollee Information – Wisconsin's contracted Enrollment Specialist will attempt outreach by mail, telephone and at outstation sites including community agencies and provider locations.

C. Disenrollment and Exemptions

All enrollees shall have the right to disenroll from the MCO within the first 90 days of enrollment. Such voluntary disenrollment shall be effective no earlier than the first day of the month following the request to disenroll. If the enrollee, legal guardian or authorized representative does not elect disenrollment during the first three (3) months of enrollment, the enrollee will be locked-in to the MCO for the remainder of the 12 month enrollment period.

All enrollees, legal guardians, or authorized representatives have the right to request an exemption. Most exemptions are granted for only a short period of time. If an enrollee wants to request an exemption, they should be referred to the Enrollment Specialist.

1. Involuntary Disenrollment - The MCO may request and the Department may approve an involuntary disenrollment, with an effective date that will be the next available benefit month based on enrollment systems logic, except for specific cases or persons where there is a situation where enrollment would be harmful to the interests of the enrollee or in which the MCO cannot provide the enrollee with appropriate medically necessary contract services for reasons beyond its control. For any request for involuntary disenrollment, MCO shall submit a disenrollment request to the Department that includes evidence attesting to cause which might include, but is not limited to:

   a. Nursing Home Disenrollment – If an enrollee is in a nursing home 90 days or longer, the enrollee shall be disenrolled. In the event enrollee transfers from the nursing home to a hospital and back to the nursing home, the applicable 90-day period shall run continuously from the first admission to nursing home and shall include any days in the hospital.

   b. Just Cause – The enrollee does not comply with critical aspects of the individual care plan or is unable to maintain a reasonable working relationship with the team or physician, despite repeated good faith efforts by MCO to communicate the seriousness of the problem and attempt alternate methods of providing care in a manner more consistent with enrollee preferences.

      The enrollee refuses critical services and/or is unwilling to meet significant conditions of participation, despite repeated good faith

efforts by MCO to communicate the seriousness of the problem and attempt alternate methods of providing care in a manner more consistent with enrollee preferences.

The enrollee is unreachable for assessment and care planning during the first 60 days of enrollment. The MCO must provide the Department with convincing evidence that proves that they have made extensive good faith efforts to reach the enrollee, including by mail, telephone and in person.

c. No Significant Contact – If MCO is unable to establish and maintain contact with the enrollee for, at minimum, an 18 month period, it may request disenrollment by presenting documentation of one or both of the following:

1) Repeated unsuccessful attempts to contact enrollee.

2) No annual assessments.

The disenrollment request will include enrollee's last assessment date and date of last contact. Internal advocates will be sent information regarding an involuntary disenrollment at the same time the MCO sends a request to the Department. The Department will make the final determination on disenrollments.

2. Ineligibility Determination

The enrollee will be disenrolled if any of these occur:

a. Out of Service Area – The enrollee moved to a location that is outside of MCO's service area(s). The date of disenrollment shall be the date the move occurred, even if this requires retroactive disenrollment. No recoupments will be made to the capitation payment to reflect a mid-month disenrollment, but any capitation payment(s) made for months subsequent to the disenrollment month will be recouped.

b. County Case Management Waiver Program/Other Managed Care Program – The enrollee is or will be participating in CIP, COP or Pace/Partnership, other home and community waivers, or other managed care programs (such as Family Care). The MCO must inform the Department of the effective dates that the enrollee is/was participating in the county waiver program or other managed care program to accommodate a timely disenrollment. Disenrollment shall be effective the first of the month in which the enrollee entered the other program. Any capitation payments made for months subsequent to disenrollment will be recouped.

c. Loss of Medicaid Eligibility – If an enrollee loses Medicaid eligibility or dies, the enrollee shall be disenrolled. The date of disenrollment shall be the date of Medicaid eligibility termination or the date of death. No recoupments will be made to the capitation payment to reflect a mid-month disenrollment, but any capitation payment(s) made for months subsequent to the disenrollment month will be recouped.

3. In the following a-i, disenrollment/exemption requests will be processed as soon as possible and will generally be effective the first day of the next month of the request, unless otherwise specified.

Disenrollments/exemptions will not normally be backdated further. The Department will not use its authority regarding backdating unreasonably. If the disenrollment or exemption is approved, the MCO will not be liable for services, as of the effective date of the disenrollment or exemption. If the Department fails to make a disenrollment determination within 30 days of receipt of all necessary information the disenrollment is considered approved.

a. Inmates of a Public Institution Disenrollment

The MCO is not liable for providing care to enrollees who are inmates in a public institution for more than a full calendar month as defined in HFS 101.03(85). Disenrollment requests may be made by the MCO and should be directed to the department's enrollment specialist. The MCO must provide documentation that shows that the enrollee is incarcerated. The disenrollment will be effective the first of the month following the first full month of incarceration or the date of Medicaid ineligibility, whichever comes first.

b. AIDS or HIV-Positive Exemption

Enrollees with a confirmed diagnosis of AIDS, as indicated by an ICD-9-CM diagnosis code, or who are HIV-Positive and on anti-retroviral drug treatment approved by the Federal Food and Drug Administration, are eligible for a permanent exemption. The MCO must not counsel or otherwise influence an enrollee or potential enrollee in such a way as to encourage exemption from enrollment or continued enrollment.

Exemption requests must come from the enrollee, legal guardian or authorized representative and should be directed to the Department's contracted Enrollment Specialist. Exemptions are processed as soon as possible and are effective on the first day of the month that anti-retroviral treatment begins or the date that the

enrollee was diagnosed with AIDS. Exemptions are not backdated more than nine (9) months from the date the request is received.

c. Pregnancy Care from Certified Nurse Midwives or Nurse Practitioners Exemption

Enrollees may be eligible for an exemption from enrollment if all of the following criteria are met:

1) The enrollee resides in a service area of a certified nurse midwife or nurse practitioner.
2) The enrollee chooses to receive her pregnancy care from a certified nurse midwife or nurse practitioner.
3) The certified nurse midwife or nurse practitioner is not affiliated with any MCO in the service area either as an independently certified provider or as a non-billing provider.

This exemption request must be made by the enrollee, legal guardian or authorized representative and should be directed to the Department's contracted Enrollment Specialist. The exemption ends when the enrollee fails to meet all criteria.

d. Commercial Insurance Exemption

Enrollees who have commercial HMO insurance may be eligible for an exemption or disenrollment from a Medicaid MCO if the commercial HMO does not participate in Medicaid. In addition, enrollees who have commercial insurance that limits them to a restricted provider network (e.g., PPOs, PHOs, etc.) may be eligible for an exemption from enrollment in a Medicaid MCO or disenrollment.

Exemption or disenrollment requests are made by the enrollee, legal guardian or authorized representative and should be directed to the Department's Enrollment Specialist. The MCO may request assistance from the Department's contracted Enrollment Specialist in situations where the enrollee has commercial insurance that limits the enrollee to providers outside the MCO's network.

When the Department's recipient eligibility file indicates commercial HMO coverage limiting an enrollee to providers outside the Medicaid MCO network, and the enrollee seeks services from the Medicaid MCO network providers, the Medicaid MCO network providers may refuse to provide services to the enrollee and refer him/her to their commercial network, except in the case of an emergency.

e. Federally Qualified Health Centers Exemption

Enrollees may be eligible for an exemption from enrollment if the following criteria are met:

1) The enrollee resides in the service area for an FQHC.
2) The enrollee chooses to receive their primary care from the FQHC.
3) The FQHC is not affiliated with any MCO within the service area.

Exemption requests must be made by the enrollee, legal guardian, or authorized representative and should be directed to the Department's Enrollment Specialist.

f. Native American Exemption

Enrollees who are Native American and members of a federally recognized tribe are eligible for a permanent exemption.

g. Ninth Month Pregnancy Exemption

Enrollees who deliver or are expected to deliver the first month they are assigned to a MCO may be eligible for exemption. In order for an exemption to occur:

1) The enrollee must have been automatically assigned or reassigned and must not have been in the MCO to which they were assigned or reassigned within the last seven (7) months; and

2) The enrollees must be seeking care from a provider (physician and/or hospital) not affiliated with the MCO to which they were assigned.

The MCO, a provider, or the enrollee, legal guardian or authorized representative may make this exemption request Exemption requests should be directed to the Department's Enrollment Specialist. The exemption ends when the enrollee fails to meet all criteria.

h. Third Trimester Pregnancy Exemption

Enrollees who are in their third trimester of pregnancy when they are expected to enter an MCO may be eligible for exemption. In order for exemption to occur:

1) The enrollee must have been automatically assigned or reassigned to their current MCO; and

2) The enrollee must be seeking care from a provider (physician and/or hospital) who is either not affiliated with the MCO to which they were assigned or is affiliated but the MCO is closed to new enrollment.

The enrollee, legal guardian, or authorized representative can only make exemption requests. Exemption requests must be made before the end of the second month in the MCO or before the birth, whichever occurs first. Exemption requests should be directed to the Enrollment Specialist. Exemption ends when the enrollee fails to meet all criteria.

i. Transplant Exemption

Enrollees who will have or have had a transplant that is considered experimental such as a liver, heart, lung, heart-lung, pancreas, pancreas-kidney or bone marrow transplant are eligible for a permanent exemption:

1) The person to get the transplant will be permanently exempted from the MCO enrollment the first of the month in which the surgery is performed.

2) In the case of autologous bone marrow transplants, the person will be permanently exempted from the MCO enrollment the date the bone marrow was extracted.

3) Enrollees who have had one (1) or more of the transplant surgeries referenced above prior to enrollment in an MCO will be permanently exempted. The effective date will be either the first of the month not more than six (6) months prior to the date of the request, or the first of the month of the MCO enrollment, whichever is later. Exemption requests may be made by the MCO.

D. Additional Services

The MCO shall not obtain enrollment through the offer of any compensation, reward, or benefit to the enrollee except for additional health-related services that have been approved by the Department.

E. Enrollment/Disenrollment Practices

The MCO must permit the Department to monitor enrollment and disenrollment practices of the MCO under this contract. The MCO will not discriminate in

enrollment/re-enrollment/disenrollment activities between individuals on the basis of health status or requirement for health care services, including those individuals who have AIDS or are HIV-Positive. This includes an enrollee with a diminished mental capacity, who is uncooperative and displays disruptive behavior and the behavior results from the enrollees' special needs. This section shall not prevent the MCO from assisting in the disenrollment process for individuals who can be in a different medical status code.

F. Re-Enrollment

A Medicaid recipient who voluntarily disenrolled from the MCO can re-enroll if the recipient meets the covered population eligibility criteria as specified in this contract. The need for MCO to perform a comprehensive assessment on the re-enrolling recipient depends on how long the recipient remained disenrolled from MCO:

1. If the recipient becomes re-enrolled less than six (6) months after the recipient's last disenrollment from MCO, then MCO does not have to perform a comprehensive assessment. MCO may use the previously developed care plan for that recipient.

2. If the recipient becomes re-enrolled at least six (6) months after the recipient's last disenrollment from MCO, then MCO must perform a comprehensive assessment for the recipient.

ARTICLE VIII

VIII. COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES

The grievance process refers to the overall system that includes complaints, grievances and appeals as defined in Article I. Medicaid enrollees may grieve any aspect of service delivery provided or arranged by the MCO to the MCO and to the Department (described in Sections A and B below). The enrollee may appeal an action as defined in Article I to the MCO, the Department and/or to the Division of Hearings and Appeals (described in section C below).

Medicaid enrollees may grieve regarding any aspect of service delivery provided or arranged by the MCO.

A. Procedures

The MCO must:

1. Have written policies and procedures that detail what the grievance system is and how it operates.

2. Identify a contact person in the MCO to receive appeals and grievances and be responsible for routing/processing.

3. Operate a complaint process which enrollees can use to get problems resolved without going through the formal, written grievance process.

4. Operate a grievance process which enrollees can use to grieve in writing.

5. Inform enrollees about the existence of the grievance process, and how to use it.

6. Attempt to resolve complaints, grievances and appeals informally.

7. Respond to grievances and appeals in writing within 10 business days of receipt of grievance or appeal, except in cases of emergency or urgent (expedited grievances/appeals) situations. This represents the first response. The MCO must resolve the grievance or appeal within two (2) business days of receipt of an expedited grievance or appeal, or sooner if possible.

8. Operate a grievance process within the MCO that enrollees can use to grieve any negative response to the Board of Directors of the MCO. The MCO Board of Directors may delegate this authority to the MCO grievance committee, but the delegation must be in writing. If a grievance committee is established, the Medicaid MCO Advocate must be a member of the committee.

9. Provide the enrollee and his or her representative opportunity, before and during the grievance process, to examine enrollee's case file, including medical records, and any other documents and records considered during the grievance process.

10. Grant the enrollee the right to appear in person before the grievance committee, to present written and oral information. The enrollee may bring a representative to this meeting. The MCO must inform the enrollee in writing of the time and place of the meeting at least seven (7) calendar days before the meeting.

11. Maintain a record keeping "log" of complaints, grievances and appeals that includes a short, dated summary of each problem, the response, and the resolution. The log must distinguish Medicaid from commercial enrollees, if the MCO does not have a separate log for Medicaid. The MCO must submit quarterly reports to the Department of all complaints, grievances and appeals. The analysis of the log will include the number of complaints, grievances and appeals divided into two (2) categories, program administration and benefits denials.

12. Maintain a record keeping system for grievances and appeals that includes a copy of the original grievance or appeal, the response, and the resolution. This system shall distinguish Medicaid from commercial enrollees, if the MCO does not have a separate system for Medicaid. (See Section B, under Article VI Computer Data Reporting System Data Records and Reports of this document regarding type of record keeping system.)

13. At the time of the initial MCO decision denying the grievance or appeal, the MCO must notify the enrollee that the decision may be reviewed by the Department or appealed to the Division of Hearings and Appeals if it involves an action.

14. Assure that the Contract Administrator or other individuals with the authority to require corrective action are involved in the grievance process.

15. Distribute to their gatekeepers and Independent Physicians Associations (IPAs) the informational flyer on enrollee's grievances rights (the ombudsman brochure). When a new brochure is available the MCO shall distribute copies to their gatekeepers and IPAs within three (3) weeks of receipt of the new brochure.

16. Ensure that the MCO's gatekeepers and IPAs have written procedures for describing how enrollees are informed of denied services and grievance procedures. The CMO will make copies of the gatekeepers' and IPAs' grievance procedures available for review upon request by the Department.

17. Inform enrollees about the availability of interpreter services during the grievance process. In addition, the MCO must provide interpreter services for non-English speaking and hearing impaired enrollees throughout the grievance process except during the Division of Hearing and Appeals fair hearing process.

B. MCO Formal Grievance Decisions/Formal Grievance Process

The enrollee may choose to use the MCO's grievance process or may directly seek the Department's review instead of using the MCO's grievance process. If the enrollee chooses to use the MCO's process, the MCO must provide an initial response within 10 business days and a final response within 30 calendar days of receiving the grievance. If the MCO is unable to resolve the grievance or appeal within 30 calendar days, the time period may be extended another 14 calendar days from receipt of the grievance or appeal if the MCO notifies the enrollee in writing that the MCO has not resolved the grievance or appeal, when the resolution may be expected and why the additional time is needed. The total timeline for the MCO to finalize a formal grievance or appeal may not exceed 45 calendar days from the date of the receipt.

Any grievance decision by the MCO may be reviewed by the Department at the enrollee's request. The Department shall conduct a review and may uphold, modify, or reject any formal grievance decision of the MCO at any time after the enrollee files the formal request. The Department will request the name and credentials of the person making the denial decision as part of the grievance process. The Department will give final response within 30 days from the date the Department has all information needed for a decision. Also, an enrollee can submit a grievance or appeal directly to the Department at any time during the grievance process. Any decision made by the Department under this section is subject to enrollee grievance rights to the extent provided by state and federal laws and rules. The Department will attempt to receive input from the enrollee and the MCO in considering grievances. This same process applies to an enrollee appeal to the Department of an MCO decision regarding an action.

In addition, an enrollee may appeal an action directly to the Division of Hearings and Appeals.

For an expedited grievance or appeal, the MCO must resolve all issues within two (2) business days of receiving the written request for an expedited grievance. The MCO must make reasonable effort to provide oral notice, in addition to written notice for the resolution.

The MCO must ensure that punitive action is not taken against anyone who either requests an expedited resolution or supports an enrollee's grievance.

C. Notifications to Enrollee

1. When the MCO, its gatekeepers, or its IPAs, discontinues, terminates, suspends, limits, or reduces a service (including services authorized by a Medicaid MCO the enrollee was previously enrolled in or services received by the enrollee on a Medicaid FFS basis), the MCO shall notify the affected enrollee(s), and his/her provider when appropriate, in writing at least 10 days before the date of action. When a CMO, its gatekeepers, or its IPAs deny coverage of a new service, the CMO must notify the

enrollee of the denial in writing. Notices for both ongoing services and new benefits must include all of the following:

a. The nature of the intended action.

b. The reasons for the intended action. The reason must be clearly stated in sufficient detail to ensure that the enrollee understands the action being taken by the HMO.

c. Duration of continued or reinstated benefits: If, at the enrollee's request the MCO continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

   1) Enrollee withdraws the appeal.

   2) Ten days pass after the MCO mails the notice of resolution of the appeal against the enrollee, unless the enrollee, within the 10-day time frame, has requested a fair hearing with the Division of Hearing and Appeals.

   3) The Division of Hearing and Appeals issues a hearing decision adverse to the enrollee.

   4) The time period or service limits of a previously authorized service has been met.

d. The enrollee has the right to examine the documentation used when the MCO made its determination.

e. The fact that interpreter services are available free of charge during the appeal process and how the enrollee can access those services.

f. The enrollee may bring a representative with him/her to the hearing.

g. The enrollee may present "new" information during the grievance and appeal process.

h. The process for requesting an oral or written expedited appeal.

i. An explanation of the enrollee's right to appeal the MCO's decision to the Department at any point in the process.

j. The fact that the enrollee may file a request for a hearing with the Division of Hearing and Appeals (DHA), with the address provided, at any point in the process but no later than 45 days after

the final MCO decision or Department decision if the enrollee appealed to the Department.

k. The fact that the enrollee can receive help in filing a request for hearing by calling either the MCO Member Advocate or the Ombudsman.

l. The address and telephone number of the MCO Member Advocate, the Enrollment Specialist and the Ombudsman.

This notice requirement does not apply when the MCO, its gatekeeper or its IPA triages an enrollee to an appropriate health care provider or when an individual health care provider determines that a service is medically unnecessary.

The Department must review and approve all notice language prior to its use by the MCO. Department review and approval will occur during the Medicaid certification process of the MCO and prior to any change of the notice language by the MCO.

D. Appeals to the Department of MCO Grievance Decisions

If the enrollee files a request for a hearing with the Division of Hearings and Appeals on or before the later of the effective date or within 10 days of the MCO mailing the notice of action to reduce, terminate or suspend benefits, upon notification by the Division of Hearings and Appeals the MCO will notify the enrollee they are eligible to continue receiving care but may be liable for care if DHA upholds the MCO's decision. If the enrollee requests that the services in question be continued pending the outcome of the fair hearing, the following conditions apply:

a. If the DHA reverses the MCO's decision, the MCO is responsible to cover the services provided to the enrollee during the administrative hearing process.

b. If the DHA upholds the MCO's decision, the MCO may pursue reimbursement for all services provided to the enrollee to the extent that the services were covered solely because of this requirement.

c. Benefits must be continued until one of the following occurs:

- The enrollee withdraws the appeal.
- A state fair hearing decision adverse to the enrollee is made.
- The authorization expires or the limit of the authorized service is met.

E. Reporting of Grievances to the Department

The MCO shall forward both the complaint, grievance and appeals reports to the Department within 30 days of the end of a quarter in the format specified in Addendum IX. Failure on the part of an MCO to submit the quarterly complaint, grievance and appeals reports in the required format within five (5) days of the due date may result in any or all sanctions available under the contract.

ARTICLE IX

IX. REMEDIES FOR VIOLATION, BREACH, OR NON-PERFORMANCE OF CONTRACT

A. Suspension of New Enrollment

Whenever the Department determines that the MCO is out of compliance with this contract, the Department may suspend the MCO's right to receive new enrollment under this contract. The Department, when exercising this option, must notify the MCO in writing of its intent to suspend new enrollment at least 30 days prior to the beginning of the suspension period. The suspension will take effect if the non-compliance remains uncorrected at the end of this period. The Department may suspend new enrollment sooner than the time period specified in this paragraph if the Department finds that enrollee health or welfare is jeopardized. The suspension period may be for any length of time specified by the Department, or may be indefinite. The suspension period may extend up to the expiration of the contract.

The Department may also notify enrollees of MCO non-compliance and provide an opportunity to disenroll back to fee-for-service.

B. Department-Initiated Enrollment Reductions

The Department may reduce the maximum enrollment level and/or number of current enrollees whenever it determines that the MCO has failed to provide one (1) or more of the contract services required under the contract or that the MCO has failed to maintain or make available any records or reports required under this contract which the Department needs to determine whether the MCO is providing contract services as required under the contract. The MCO shall be given at least 30 days to correct the non-compliance prior to the Department taking any action set forth in this paragraph. The Department may reduce enrollment sooner than the time period specified in this paragraph if the Department finds that enrollee health or welfare is jeopardized.

C. Other Enrollment Reductions

The Department may also suspend new enrollment or disenroll recipients in anticipation of the MCO not being able to comply with federal or state law at its current enrollment level. Such suspension shall not be subject to the 30-day notification requirement.

D. Withholding of Capitation Payments and Orders to Provide Services

Notwithstanding the provisions of the contract, the Department may withhold portions of capitation payments as liquidated damages or otherwise recover damages from the MCO on the following grounds:

1. Whenever the Department determines that the MCO has failed to provide one (1) or more of the medically necessary Medicaid-covered contract services required under the contract, the Department may either order the MCO to provide such service, or withhold a portion of the MCO's capitation payments for the following month or subsequent months, such portion withheld to be equal to the amount of money the Department must pay to provide such services.

   If the Department orders the MCO to provide services under this section and the MCO fails to provide the services within the timeline specified by the Department, the Department may withhold an amount up to 150% of the FFS amount for such services from the MCO's capitation payments.

   When it withholds payments under this section, the Department must submit to the MCO a list of the participants for whom payments are being withheld, the nature of the service(s) denied, and payments the Department must make to provide medically necessary services.

   If the Department acts under this section and subsequently determines that the services in question were not covered services:

   a. In the event the Department withheld payments it shall restore to the MCO the full capitation payment; or

   b. In the event the Department ordered the MCO to provide services under this section it shall pay the MCO the actual documented cost of providing the services.

2. If the MCO fails to submit required data and/or information to the Department or the Department's authorized agents, or fails to submit such data or information in the required form or format, by the deadline specified by the Department, the Department may immediately impose liquidated damages in the amount of $1,500 per day for each day beyond the deadline that the MCO fails to submit the data or fails to submit the

data in the required form or format, such liquidated damages to be deducted from the MCO's capitation payments.

3. If the MCO fails to submit state and federal reporting and compliance requirements for abortions, hysterectomies and sterilization's, the Department may impose liquidated damages in the amount of $10,000 per reporting period.

4. If the MCO fails to correct an error to the encounter record within the time frame specified, the Department may assess a sanction of $5.00 per erred encounter record per month until the error has been corrected. The sanction amount will be deducted from the MCO's capitation payment. When applied, these sanctions will be calculated and assessed on a quarterly basis.

   If upon audit or review, the Department finds that the MCO has, without Department approval, removed an erred encounter record to avoid liquidated damages, the Department may assess liquidated damages for each day from the date of original error notification until the date of correction.

   The term "erred encounter record" means an encounter record that has failed an edit when a correction is expected by the Department.

   The following criteria will be used prior to assessing liquidated damages:

   a. The Department will calculate a percentage rate by dividing the number of erred records not corrected within 90 days (numerator), by the total number of records in error (denominator) and multiply the result by 100.

   b. Records failing non-critical edits, as defined in the Wisconsin Medicaid MCO Encounter Data User Manual, will not be included in the numerator.

   c. If this rate is 2% or less, liquidated damages will not be assessed.

   d. The Department will calculate this rate each month.

5. Whenever the Department determines that the MCO has failed to perform an administrative function required under this contract, the Department may withhold a portion of future capitation payments. For the purposes of this section, "administrative function" is defined as any contract obligation other than the actual provision of contract services. The amount withheld by the Department under this section will be an amount that the Department determines in the reasonable exercise of its discretion to approximate the cost to the Department to perform the function. The

Department may increase these amounts by 50% for each subsequent non-compliance.

Whenever the Department determines that the MCO has failed to perform the administrative functions, the Department may withhold a portion of future capitation payments sufficient to directly compensate the Department for the Medicaid program's costs of providing health care services and items to individuals insured by said insurers and/or the insurers/employers represented by said third party administrators.

6. In any case under this contract where the Department has the authority to withhold capitation payments, the Department also has the authority to use all other legal processes for the recovery of damages.

7. Not withstanding the provisions of the contract, in any case where the Department withholds a portion of capitation payments under the contract, the following procedures shall be used:

   a. The Department will notify the MCO's contract administrator no later than the second business day after the Department's deadline that the MCO has failed to submit the required data or the required data cannot be processed.

   b. The MCO will be subject to liquidated damages without further notification per submission per data file or report, beginning on the second business day after the Department's deadline.

   c. If the late submission of data is for encounter data, and the MCO responds with a submission of the data within five (5) business days of the deadline, the Department will rescind liquidated damages if the data can be processed according to the criteria published in the Wisconsin Medicaid MCO Encounter Data User Manual. The Department will not edit the data until the process period in the subsequent month.

   d. If the late submission is for any other required data or report, and the MCO responds with a submission of the data in the required format within five (5) business days of notification, the Department will rescind liquidated damages and immediately process the data or report.

   e. If the MCO repeatedly fails to submit required data or reports, or repeatedly submits data that cannot be processed the Department will require the MCO to develop an action plan to comply with the contract requirements that meets Department approval.

   f. If the MCO's corrective action plan from (e) above is inadequate, the MCO continues to submit data beyond the deadline, or

continues to submit data that cannot be processed after a corrective action plan has been implemented, the Department will invoke the remedies from Suspension of New Enrollment, from Department-Initiated Enrollment Reductions, or both, in addition to liquidated damages that may have been imposed for a current violation.

g. If the MCO discontinues contracting with the Department at the end of a contract period, but reports or data are due for a future contract period, the Department retains the right to withhold two (2) months of capitation payments which will be released to the MCO once the reports or data are submitted and accepted.

E. Inappropriate Payment Denials

The MCO that inappropriately fails to provide or deny payments for services may be subject to suspension of new enrollments, withholding, in full or in part, of capitation payments, contract termination, or refusal to contract in a future time period, as determined by the Department. The Department will select among these sanctions based upon the nature of the services in question, whether the failure or denial was an isolated instance or a repeated pattern or practice, and whether the health of a enrollee was injured, threatened or jeopardized by the failure or denial. This applies not only to cases where the Department has ordered payment after appeal, but also to cases where no appeal has been made (i.e., the Department is knowledgeable about the documented abuse from other sources).

F. Sanctions

Section 1903(m)(5)(B)(ii) of the Social Security Act vests the Secretary of the Department of Health and Human Services with the authority to deny Medicaid payments to the MCO for enrollees who enroll after the date on which the MCO has been found to have committed one of the violations identified in the federal law. State payments for enrollees of the contracting organization are automatically denied whenever, and for so long as, federal payment for such enrollees has been denied as a result of the commission of such violations.

G. Sanctions and Remedial Actions

The Department may pursue all sanctions and remedial actions with the MCO that are taken with Medicaid FFS providers, including any civil penalties not to exceed the amounts specified in the Balanced Budget Amendment of 1997, P.L.105-33 Sec. 4707 (a) [42 U.S.C.1396(v)(d)(2)].

H. Temporary Management

The State may impose temporary management if it finds that the MCO has repeatedly failed to meet substantive requirements in Section 1903(m) or Section 1932 of the Act.

I. Terminate Enrollment

The State may also grant enrollees the right to terminate enrollment without cause and must notify the affected enrollees of their right to terminate enrollment.

ARTICLE X

X. TERMINATION AND MODIFICATION OF CONTRACT

A. Termination by Mutual Consent

This contract may be terminated at any time by mutual written agreement of both the MCO and the Department.

B. Unilateral Termination

This contract between the parties may be terminated only as follows:

1. Either party may terminate this contract without cause at any time. In such case, the party initiating such termination procedures must notify the other party, at least 90 days prior to the proposed date of termination, of its intent to terminate this contract. The actual date of termination will depend on the Department's ability to terminate the contract in an orderly fashion considering the administrative needs of the Department. Termination by the Department under these circumstances shall impose an obligation upon the Department to pay the Contractor's reasonable and necessarily incurred termination expenses.

2. Unilateral Termination with Cause

    a. This contract may be terminated at any time, by either party, due to modifications mandated by changes in federal or state law, regulations, or policies that materially affect either party's rights or responsibilities under this contract. In such case, the party initiating such termination procedures must notify the other party, at least 90 days prior to the proposed date of termination, of its intent to terminate this contract. Termination by the Department under these circumstances shall impose an obligation upon the Department to pay the Contractor's reasonable and necessarily incurred termination expenses.

    b. Either party may terminate this contract at any time, if it determines that the other party has substantially failed to perform any of its functions or duties under this contract. In such event, the party exercising this option must notify the other party, in writing, of this intent to terminate this contract and give the other party 30 days to correct the identified violation, breach or non-performance of

contract. If such violation, breach or non-performance of contract is not satisfactorily addressed within this time period, the exercising party may terminate this contract. The termination date shall always be the last day of a month. The contract may be terminated by the Department sooner than the time period specified in this paragraph if the Department finds that enrollee health or welfare is jeopardized by continued enrollment in the MCO. A "substantial failure to perform" for purposes of this paragraph includes any violation of any requirement of this contract that is repeated or on-going, that goes to the essentials or purpose of the contract, or that injures, jeopardizes or threatens the health, safety, welfare, rights or other interests of enrollees.

c. This contract may be terminated at any time, by either party, in the event federal or state funding of contractual services rendered by the Contractor become or will become permanently unavailable. In the event it becomes evident state or federal funding of claims payments or contractual services rendered by the Contractor will be temporarily suspended or unavailable, the Department shall immediately notify the Contractor, in writing, identifying the basis for the anticipated unavailability or suspension of funding. Upon such notice, the Department or the Contractor may suspend performance of any or all of the Contractor's obligations under this contract if the suspension or unavailability of funding will preclude reimbursement for performance of those obligations. The Department or Contractor shall attempt to give notice of suspension of performance of any or all of the Contractor's obligations by 60 calendar days prior to said suspension, if this is possible; otherwise, such notice of suspension should be made as soon as possible. In the event funding temporarily suspended or unavailable is reinstated, the Contractor may remove suspension hereunder by written notice to the Department, to be made within 30 calendar days from the date the funds are reinstated. In the event the Contractor elects not to reinstate services, the Contractor shall give the Department written notice of its reasons for such decision, to be made within 30 calendar days from the date the funds are reinstated. The Contractor shall make such decision in good faith and will provide to the Department documentation supporting its decision. In the event of termination under this Section, this contract shall terminate without termination costs to either party.

C. Obligations of Contracting Parties upon Termination

When termination of the contract occurs, the following obligations shall be met by the parties:

1. Where this contract is terminated unilaterally by the Department, due to non-performance by the MCO or by mutual consent with termination initiated by the MCO:

    a. The Department shall be responsible for notifying all enrollees of the date of termination and process by which the enrollees will continue to receive contract services.

    b. The MCO shall be responsible for all expenses related to said notification.

    c. The Department shall grant the MCO a hearing before termination occurs. The Department shall notify the enrollees of the hearing and allow them to disenroll from the MCO without cause.

2. Where this contract is terminated on any basis not given in 1 including non-renewal of the contract for a given contract period:

    a. The Department shall be responsible for notifying all enrollees of the date of termination and process by which the enrollees will continue to receive contract services.

    b. The Department shall be responsible for all expenses relating to said notification.

3. Where this contract is terminated for any reason the following payment criteria will apply:

    a. Any payments advanced to the MCO for coverage of enrollees for periods after the date of termination shall be returned to the Department within the period of time specified by the Department.

    b. The MCO shall supply all information necessary for the reimbursement of any outstanding Medicaid claims within the period of time specified by the Department.

    c. If a contract is terminated, recoupments will be handled through a payment by the MCO within 90 days of contract termination.

D. Where this Contract is Terminated on Any Basis Not Given Including Non-Renewal of the Contract for a Given Contract Period

1. The Department shall be responsible for notifying all enrollees of the date the contract will end and the process by which the enrollees will continue to receive contract services.

2. The MCO shall be responsible for all expenses related to said notification.

3. Any payments advanced to the MCO for coverage of enrollees for periods after the date the contracts ends shall be returned to the Department within the period of time specified by the Department.

4. Recoupments will be handled through a payment by the MCO within 90 days of the end of the contract.

E. Modification

This contract may be modified at any time by written mutual consent of the MCO and the Department or when modifications are mandated by changes in federal or state laws. If changes in state or federal laws, rules or regulations require the Department to modify its contract with the MCO, the MCO will receive written notice.

If the Department exercises its right to renew this contract, as allowed, the Department will recalculate the capitation rate for succeeding calendar years. The MCO will have 30 days to accept the new capitation rate in writing or to initiate termination of the contract. If the Department changes the reporting requirements during the contract period, the MCO shall have 180 days to comply with such changes or to initiate termination of the contract.

ARTICLE XI

XI. INTERPRETATION OF CONTRACT LANGUAGE

The Department has the right to final interpretation of the contract language when disputes arise. The MCO has the right to appeal to the Department if it disagrees with the Department's decision. Until a decision is reached, the MCO shall abide by the interpretation of the Department.

ARTICLE XII

XII. CONFIDENTIALITY OF RECORDS AND HIPAA REQUIREMENTS

A. Authorized Access to Information

The parties agree that all information, records, and data collected in connection with this contract shall be protected from unauthorized disclosure as provided in Chapter 19, Subchapter II, Wis. Statutes, HFS 108.01, Wis. Adm. Code, and 42 CFR 431 Subpart F and 42 CFR 438 Subpart F. Except as otherwise required by law, access to such information shall be limited by the MCO and the Department to persons who, or agencies which, require the information in order to perform their duties related to this contract, including the U.S. Department of

Health and Human Services and such others as may be required by the Department.

B. Media Contacts

The MCO agrees to forward to the Department all media contacts regarding Medicaid enrollees or the Medicaid program.

C. Compliance with HIPAA

Regarding the services provided under this contract, the MCO will comply with all applicable health data and information privacy and security policies, standards and regulations as may be adopted or promulgated under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 in final form, and as amended or revised from time to time. This includes cooperating with the Department in amending this contract, or developing a new agreement, if the Department deems it necessary to meet the Department's obligations under HIPAA.

D. Trading Partner requirements under HIPAA: (For the purposes of this section Trading Partner means the MCO.)

1. Trading Partner Obligations:

   a. Trading Partner must not change any definition, data condition or use of a data element or segment as prescribed in the HHS Transaction Standard Regulation (45 CFR Part 62.915(a)).

   b. Trading Partner must not add any data elements or segments to the maximum data set as described in the HHS Transaction Standard Regulation (45 CFR Part 62.915(b)).

   c. Trading Partner hereby must not use any code or data elements that are either marked "not used" in the HHS Transaction Standard's implementation specifications or are not in the HHS Transaction Standard's implementation specifications (45 CFR Part 62.915(c)).

   d. Trading Partner must not change the meaning or intent of any of the HHS Transaction Standard's implementation specifications (45 CFR Part 62.915(d)).

   e. Trading Partner must submit a new Trading Partner profile form in writing if any of the information provided as part of the Trading Partner profile form is modified.

2. Trading Partner understands that there exists the possibility that the Department or others may request an exception from the uses of a standard in the HHS Transaction Standards. If this occurs, Trading Partner must participate in such test modification (45 CFR Part 162.904(a)(4)).

3. Trading Partners or Trading Partner's Business Associate have responsibilities to adequately test business rules appropriate to their types and specialties.

4. Trading Partner or their Business Associate agrees to cure transaction errors or deficiencies identified by the Department.

5. Trading Partner or Trading Partner's Business Associate understands that from time-to-time HHS may modify and set compliance dates for the HHS Transaction Standards. Trading Partner or Trading Partner's Business associate must incorporate by reference any such modifications or changes (45 CFR Part 160.140).

6. The Department and the Trading Partner agree to keep open code sets being processed or used for at least the current billing period or any appeal period, whichever is longer (45 CFR Part 162.925(c)(2)).

7. Privacy:

    a. The Trading Partner or the Trading Partner's Business Associate will comply with all applicable state and federal privacy statutes and regulations concerning the treatment of Protected Health Information (PHI).

    b. The Department and the Trading Partner or Trading Partner's Business Associate will promptly notify the other party of any unlawful or unauthorized use or disclosure of PHI that may have an impact on the other party that comes to the party's attention, and will cooperate with the other party in the event that any litigation arises concerning the unlawful or unauthorized disclosure of use of PHI.

    c. The Department retains all rights to seek injunctive relief to prevent or stop the unauthorized use or disclosure of PHI by the Trading Partner, Trading Partner's Business Associate, or any agent, contractor or third party that received PHI from the Trading Partner.

8. Security:

    a. The Department and the Trading Partner or Trading Partner's Business Associate must maintain reasonable security procedures to prevent unauthorized access to data, data transmissions, security

access codes, envelope, backup files, and source documents. Each party will immediately notify the other party of any unauthorized attempt to obtain access to or otherwise tamper with data, data transmissions security access codes, envelope, backup files, source documents other party's operating system when the attempt may have an impact on the other party.

b. The Department and the Trading Partner or Trading Partner's Business Associate must develop, implement, and maintain appropriate security measures for its own operating system. The Department and the Trading Partner or Trading Partner's Business Associate must document and keep current its security measures. Each party's security measures will include, at a minimum, the requirements and implementation features set forth in 'site specific HIPAA rule' and all applicable HHS implementation guidelines.

ARTICLE XIII

XIII. DOCUMENTS CONSTITUTING CONTRACT

The documents listed in this Article constitute the entire contract between the parties and no other expression, whether oral or written, constitutes any part of this contract.

A. Current Documents

In addition to this base agreement, the contract between the Department and the MCO includes, existing Medicaid provider publications addressed to the MCO, the terms of the most recent MCO Certification Application issued by this Department for Medicaid MCO contracts, any questions and answers released pursuant to said MCO Certification Application by the Department, and an MCO's signed application. The terms of the MCO Certification Application are part of this contract. In the event of any conflict in provisions among these documents, the terms of this base agreement will prevail. The provisions in any question and answer document will prevail over the MCO Certification Application and the MCO Certification Application terms shall prevail over any conflict with an MCO's actual signed application.

B. Future Documents

The MCO is required, by this contract, to comply with all future Medicaid Provider Publications addressed to the MCO and Contract Interpretation Bulletins issued pursuant to this contract. The documents listed in this Article constitute the entire contract between the parties. No other oral or written expression, constitutes any part of this contract.

ARTICLE XIV

XIV. MISCELLANEOUS

A. Indemnification

The MCO agrees to defend, indemnify and hold the Department harmless, with respect to any and all claims, costs, damages and expenses, including reasonable attorney's fees, which are related to or arise out of:

1. Any failure, inability, or refusal of the MCO or any of its subcontractors to provide contract services.

2. The negligent provision of contract services by the MCO or any of its subcontractors.

3. Any failure, inability or refusal of the MCO to pay any of its subcontractors for contract services.

B. Independent Capacity of Contractor

Department and MCO agree that MCO and any agents or employees of MCO, in the performance of this contract, shall act in an independent capacity, and not as officers or employees of Department.

C. Omissions

In the event that either party hereto discovers any material omission in the provisions of this contract which such party believes is essential to the successful performance of this contract, said party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments as may be necessary to perform the objectives of this contract.

D. Choice of Law

This contract shall be governed by and construed in accordance with the laws of the State of Wisconsin. MCO shall be required to bring all legal proceedings against Department in Wisconsin State courts.

E. Waiver

No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be

construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained.

F. Severability

If any provision of this contract is declared or found to be illegal, unenforceable, invalid or void, then both parties shall be relieved of all obligations arising under such provision; but if such provision does not relate to payments or services to Medicaid enrollees and if the remainder of this contract shall not be affected by such declaration or finding, then each provision not so affected shall be enforced to the fullest extent permitted by law.

G. Survival

The terms and conditions contained in this contract that by their sense and context are intended to survive the completion of performance shall so survive the completion, expiration or termination of the contract. This specifically includes, but is not limited to, recoupments and confidentiality provisions.

H. Force Majeure

Both parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this contract as a result of a catastrophic occurrence or natural disaster including but not limited to an act of war, and excluding labor disputes.

I. Headings

The Article and section headings used herein are for reference and convenience only and do not affect its interpretation.

J. Assignability

Except as allowed under subcontracting, the contract is not assignable by the MCO either in whole or in part, without the prior written consent of the Department.

K. Right to Publish

The MCO must obtain prior written approval from the Department before publishing any materials on subjects addressed by this contract.

ARTICLE XV

XV. MCO-SPECIFIC CONTRACT TERMS

A. Renewals

By mutual written agreement of the parties, there may be one (1) one-year renewal of the term of the contract. An agreement to renew must be effected at least 45 calendar days prior to the expiration date of any contract term. The terms and conditions of the contract shall remain in full force and effect throughout any renewal period, unless modified under the provision of the contract.

B. Service Coverage/Payment

The specific terms of the Medicaid contract between DHFS and the MCO are:

1. County in which enrollment is accepted: Dane County.

2. The specific terms of the Medicaid MCO contract to which the MCO agrees are set forth in this contract. The capitation rates to which the MCO agrees are indicated by the Department below.

3. The MCO maximum enrollment limit is designated in the certification application. The number of enrollees may exceed the maximum by up to 5% on a temporary basis. The Department does not guarantee any minimum enrollment level.

4. The following initial capitation rates in Table 1 will be paid for the covered population for the period May 1, 2006, through December 31, 2006:

Table 1

				Total MCE	**MCE less Chiro**	**MCE With Chiro less Dental**	**MCE less Chiro and Dental**
Med Stat Code 21	Medicaid Only	<30	Male	$398.60	$397.62	$396.01	$395.02
			Female	$392.70	$391.73	$390.15	$389.18
		30-39	Male	$529.58	$528.27	$526.15	$524.84
			Female	$562.96	$561.57	$559.31	$557.91
		40-64	Male	$661.25	$659.61	$656.97	$655.33
			Female	$729.90	$728.10	$725.17	$723.36
		65+	Male	$451.60	$450.48	$448.67	$447.55
			Female	$618.39	$616.86	$614.38	$612.85
Med Stat Code 21	Dual Eligible	<30	Male	$186.68	$186.38	$183.18	$182.89
			Female	$149.87	$149.63	$147.06	$146.82
		30-39	Male	$189.98	$189.68	$186.42	$186.12
			Female	$204.13	$203.81	$200.30	$199.98
		40-64	Male	$220.37	$220.02	$216.23	$215.88
			Female	$225.84	$225.48	$221.60	$221.24
		65+	Male	$189.17	$188.87	$185.62	$185.32
			Female	$214.17	$213.83	$210.15	$209.81
SSI-Related	Medicaid Only	<30	Male	$614.41	$613.87	$610.97	$610.43
			Female	$477.54	$477.12	$474.87	$474.45
		30-39	Male	$679.06	$678.46	$675.26	$674.66
			Female	$716.41	$715.78	$712.40	$711.77
		40-64	Male	$1,195.84	$1,194.78	$1,189.15	$1,188.09
			Female	$943.61	$942.78	$938.33	$937.50
		65+	Male	$467.66	$467.25	$465.05	$464.64
			Female	$440.95	$440.56	$438.48	$438.09
SSI-Related	Medicaid Only	<30	Male	$167.49	$167.30	$164.21	$164.02
			Female	$145.20	$145.03	$142.35	$142.19
		30-39	Male	$222.79	$222.53	$218.42	$218.17
			Female	$184.81	$184.60	$181.18	$180.97
		40-64	Male	$243.08	$242.80	$238.31	$238.03
			Female	$224.15	$223.89	$219.76	$219.51
		65+	Male	$182.62	$182.41	$179.04	$178.83
			Female	$155.51	$155.33	$152.46	$152.28
MAPP	Medicaid Only	All	All	$1,048.25	$1,045.28	1,041.14	1,038.17
MAPP	Dual Eligible	All	All	$280.86	$280.29	$276.18	$275.61

Case Mix Adjustment: The Department will conduct an analysis comparing actual MCO Medicaid enrollees diagnosis and service usage intensity (utilization and costs) with the comparable fee-for-service-equivalent population using the Chronic Illness and Disability Payment System (CDPS).

The Department will make case mix adjusted payments to the MCO if the CDPS-based adjustment method is approved by CMS. The payment rates for the MA only enrollees will be adjusted based upon the final outcome of the CDPS analysis as applied to the initial rates under Column "Total MCE," subject to CMS approval. This retrospective reconciliation of the composite CDPS weight based on actual enrollment will be calculated within sixty days following the end of each calendar year within the contract period.

Expedited Case Mix Adjustment: The Department may adjust the initial rates whenever a significant variance occurs from the index used to calculate the initial rates under Column "Total MCE." Significant variance is defined as a case mix variance greater than 5.0% from the average index. Any such adjustment will be effective no sooner than 45 days following the calculation of the variance.

5. The respective rights and obligation of the parties as set forth in this contract shall commence on May 1, 2006, and, unless earlier terminated, shall remain in full force and effect through December 31, 2007.

In WITNESS WHEREOF, The State of Wisconsin has executed this agreement:

Managed Care Organization	**State of Wisconsin**
Official Signature	Official Signature
Printed Name	Printed Name
Title	Title
Date	Date

SUBCONTRACT FOR CHIROPRACTIC SERVICES

NOTE: The following subcontract with the Department for Chiropractic Services is not effective unless signed below.

THIS AGREEMENT is made and entered into by and between MCO and the DHFS.

The parties agree as follows:

1. The Department agrees to be at risk for and pay claims for chiropractic services covered under this contract.

2. MCO agrees to a deduction from the capitation rate of an amount of money based on the cost of chiropractic services. This deduction is reflected in the contract that is being signed on the same date.

3. This is the only subcontract for services that the Department is entering into with MCO.

4. The provisions of the contract regarding subcontracts, in this contract, do not apply to this subcontract.

5. The term of this subcontract is for the same period as this contract between MCO and the Department for medical services.

Managed Care Organization	**State of Wisconsin**
Official Signature	Official Signature
Printed Name	Printed Name
Title	Title
Date	Date

ADDENDUM I

SUBCONTRACTS AND MEMORANDA OF UNDERSTANDING

NOTE: This section does not apply to subcontracts between the Department and the MCO. The Department shall have sole authority to determine the conditions and terms of such subcontracts.

1. Original review and approval for the MCO that did not have a Medicaid/MCO contract in the prior contract period, or that are going to accept enrollment of Medicaid recipients in a new service area (county).

2. The Department may approve, approve with modification, or deny subcontracts under this contract at its sole discretion. The Department may, at its sole discretion and without the need to demonstrate cause, impose such conditions or limitations on its approval of a subcontract, as it deems appropriate. The Department may consider such factors, as it deems appropriate to protect the interests of the State and recipients, including but not limited to the proposed subcontractor's past performance. DHFS will give the MCO (1) 120 days to implement a change that requires the MCO to find a new subcontractor, and (2) 60 days to implement any other change required by DHFS. DHFS will acknowledge the approval or disapproval of a subcontract within 14 days after its receipt from the MCO.

3. The Department will review and approve or disapprove each subcontract before contract signing. Any disapproval of subcontracts may result in the application by the Department of remedies pursuant to this Addendum of this contract. The Department's subcontract review will assure that the MCO has inserted the following standard language in subcontracts (except for specific provisions that are inapplicable in a specific MCO management subcontract).

4. Subcontractor (hereafter identified as subcontractor) agrees to abide by all applicable provisions of the (MCO NAME)'s contract with the DHFS, hereafter referred to as Medicaid/MCO contract. Subcontractor compliance with the Medicaid/MCO contract specifically includes but is not limited to the following requirements:

    a. Subcontractor uses only Medicaid-certified providers in accordance with the Medicaid/MCO contract.

    b. No terms of this subcontract are valid which terminate legal liability of MCO.

    c. Subcontractor agrees to participate in and contribute required data to MCO QAPI programs as required in the Medicaid/MCO contract.

    d. Subcontractor agrees to abide by the terms of the Medicaid/MCO contract for the timely provision of emergency and urgent care. Where applicable, subcontractor agrees to follow those procedures for handling urgent and emergency care cases

stipulated in any required hospital/emergency room MOUs signed by MCO in accordance with the Medicaid/MCO contract.

e. Subcontractor agrees to submit MCO encounter data in the format specified by the MCO, so the MCO can meet the Department specifications required by the Medicaid/MCO contract. MCO will evaluate the credibility of data obtained from subcontracted vendors' external databases to ensure that any patient-reported information has been adequately verified.

f. Subcontractor agrees to comply with all non-discrimination requirements in the Medicaid/MCO contract.

g. Subcontractor agrees to comply with all record retention requirements and, where applicable, the special reporting requirements on abortions, sterilizations, hysterectomies, and HealthCheck requirements.

h. Subcontractor agrees to provide representatives of MCO, as well as duly authorized agents or representatives of DHFS and the federal Department of Health and Human Services, access to its premises and its contract and/or medical records in accordance with the Medicaid/MCO contract. Subcontractor agrees otherwise to preserve the full confidentiality of medical records in accordance with the Medicaid/MCO contract.

i. Subcontractor agrees to the requirements for maintenance and transfer of medical records stipulated in the Medicaid/MCO contract.

j. Subcontractor agrees to ensure confidentiality of family planning services in accordance with the Medicaid/MCO contract.

k. Subcontractor agrees not to create barriers to access to care by imposing requirements on recipients that are inconsistent with the provision of medically necessary and covered Medicaid benefits (e.g., COB recovery procedures that delay or prevent care).

l. Subcontractor agrees to clearly specify referral approval requirements to its providers and in any sub-subcontracts.

m. Subcontractor agrees not to bill a Medicaid enrollee for medically necessary services covered under the Medicaid/MCO contract and provided during the enrollee's period of MCO enrollment. Subcontractor also agrees not to bill enrollees for any missed appointments while the enrollee was eligible under the Medicaid Program. This provision will remain to be in effect even if the MCO becomes insolvent. However, if an enrollee agrees in writing to pay for a non-Medicaid-covered service, then the MCO, MCO provider, or MCO subcontractor can bill.

The standard release form signed by the enrollee at the time of services does not relieve the MCO and its providers and subcontractors from the prohibition against

billing a Medicaid enrollee in the absence of a knowing assumption of liability for a non-Medicaid-covered service. The form or other type of acknowledgment relevant to Medicaid enrollee liability must specifically state the admissions, services, or procedures that are not covered by Medicaid.

n. Subcontractors must forward to the MCO medical records pursuant to grievances, within 15 working days of the MCO's request. If the subcontractor does not meet the 15-day requirement, the subcontractor must explain why and indicate when the medical records will be provided.

o. Subcontractor agrees to abide by the terms regarding appeals to the MCO and to the Department regarding the MCO's nonpayment for services providers render to Medicaid enrollees.

p. Subcontractor agrees to abide by the MCO marketing/informing requirements. Subcontractor will forward to the MCO for prior approval all flyers, brochures, letters, and pamphlets the subcontractor intends to distribute to its Medicaid enrollees concerning its MCO affiliation(s) or changes in affiliation, or relating directly to the Medicaid population. Subcontractor will not distribute any "marketing" or enrollee informing materials without the consent of the MCO and the Department.

5. Rates – The Department will also review MCO management subcontracts to assure that rates are reasonable.

a. Subcontracts for MCO management must clearly describe the services to be provided and the compensation to be paid.

b. Any potential bonus, profit-sharing, or other compensation not directly related to costs of providing goods and services to the MCO, shall be identified and clearly defined in terms of potential magnitude and expected magnitude during the Medicaid MCO contract period.

c. Any such bonus or profit sharing shall be reasonable compared to services performed. The MCO shall document reasonableness.

d. A maximum dollar amount for such bonus or profit sharing shall be specified for the contract period.

e. Requirements (a) through (d) do not have to relate to non-Medicaid enrollees if the MCO wishes to have separate arrangements for the Medicaid enrollees.

6. Prior Medicaid MCO Contractors with No Service Area Additions – Subcontract review for the MCO that has had a SSI Medicaid/MCO contract in the previous contract period and is not expanding into a new service area during the current contract period.

a. The MCO shall submit, and the Department shall review, before signing this contract, an affidavit that the contract language required above in all Medicaid/ MCO subcontracts is included in all the MCO's subcontracts for medical services (and dental care, if covered). The affidavit shall specify the expiration date of all subcontracts.

b. The MCO shall submit the MCO management subcontract for review as specified for new contractors above.

7. New and Altered Subcontracts During Contract Period – Review and approval of new subcontracts and changes in approved subcontracts during the contract period.

a. New subcontracts and changes in approved subcontracts shall be reviewed and approved by the Department before taking effect. This requirement will be considered met if the Department has not responded within 15 consecutive days of the date of departmental receipt of request.

b. This review requirement applies to changes that affect the amount, duration, scope, location, or quality of services. In other words, technical changes do not have to be approved.

c. Changes in rates paid do not have to be approved, with the exception of changes in the amounts paid to MCO management services subcontractors.

d. MCO shall submit notice within 10 days to the Department of addition or deletion of subcontracts involving (i) a clinic or group of physicians, (ii) an individual physician, (iii) a mental health provider and/or clinic.

e. MCO shall notify the Department's enrollment broker within 10 days of additions to, and deletions from, the provider network.

f. The MCO shall submit to the enrollment broker an electronic listing of all network Medicaid providers, facilities and pharmacies within the first 10 days of each calendar quarter in a mutually agreed upon format approved by the Department. This listing will include, but is not limited to, provider name, provider number, address, telephone number, and specialty as well as indicators designating whether a provider can be selected as a PCP, and whether the PCP is accepting new patients. The listing shall include only Medicaid certified providers who are contracted with the MCO to provide contract services to Medicaid enrollees.

g. The MCO must send written notification, within 15 days after receipt or issuance of the termination notice, to each enrollee whose PCP, mental health provider, gatekeeper or dental clinic terminates a contract with the MCO. The Department must approve notifications before they are sent to enrollees.

h. MCO shall be required to submit transition plans whenever primary care provider(s), mental health provider(s), gatekeeper(s) or dental clinic(s) terminate

their contractual relationship with the MCO. The transition plan will address continuity of care issues, enrollee notification and any other information required by the Department to assure adequate enrollee access. The Department will approve, deny, or modify the transition plan prior to the effective date of the subcontract change.

8. Disclosure Statements

Ownership – MCO agrees to submit to the Department within 30 days of contract signing full and complete information as to the identity of each person or corporation with an ownership or control interest in the MCO, or any subcontractor in which the MCO has a 5% or more ownership interest.

a. Definition of "Person with an Ownership or Control Interest" – A "person with an ownership or control interest" means a person or corporation that:

1) Own, directly or indirectly, 5% or more of the MCO's capital or stock or receives 5% or more of its profits (see Subsection b);

2) Has an interest in any mortgage, deed of trust, note, or other obligation secured in whole or in part by the MCO or by its property or assets, and that interest is equal to or exceeds 5% of the total property and assets of the MCO; or

3) Is an officer or director of the MCO (if it is organized as a corporation) or is a partner in the MCO (if it is organized as a partnership).

b. Calculation of 5% Ownership or Receipt of Profits – The percentage of direct ownership or control is calculated by multiplying the percent of interest that a person owns by the percent of the MCO's assets used to secure the obligation. Thus, if a person owns 10% of a note secured by 60% of the MCO's assets, the person owns 6% of the MCO.

The percentage of indirect ownership or control is calculated by multiplying the percentages of ownership in each organization. Thus, if a person owns 10% of the stock in a corporation that owns 80% of the stock of the MCO, the person owns 8% of the MCO.

c. Information to be Disclosed – The following information must be disclosed:

1) The name and address of each person with an ownership or controlling interest of 5% or more in the MCO or in any subcontractor in which the MCO has direct or indirect ownership of 5% or more;

2) A statement as to whether any of the persons with ownership or control interest is related to any other of the persons with ownership or controlling interest as spouse, parent, child, or sibling; and

3) The name of any other organization in which the person has ownership or controlling interest. This is required to the extent that the MCO can obtain this information by requesting it in writing. The MCO must keep copies of all of these requests and responses to them, make them available upon request, and advise the Department when there is no response to a request.

d. Potential Sources of Disclosure Information – This information may already have been reported on Form HCFA-1513, "Disclosure of Ownership and Control Interest Statement." Form HCFA-1513 is likely to have been completed in two different cases. First, if the MCO is federally qualified and has a Medicare contract, it is required to file Form HCFA-1513 with HCFA within 120 days of the MCO's fiscal year end. Secondly, if the MCO is owned by or has subcontracts with Medicaid providers who are reviewed by the State survey agency, these providers may have completed Form HCFA-1513 as part of the survey process. If Form HCFA-1513 has not been completed, the MCO may supply the ownership and control information on a separate report or submit reports filed with the State's insurance or health regulators as long as these reports provide the necessary information for the prior 12-month period.

e. As directed by the Center for Medicaid/Medicare Services (CMS) Regional Office (RO), this Department must provide documentation of this disclosure information as part of the prior approval process for contracts. This documentation must be submitted to the Department and the RO prior to each contract period. If the MCO has not supplied the information that must be disclosed, a contract with the MCO is not considered approved for this period of time and no FFP is available for the period of time preceding the disclosure.

f. Debarred and Suspended Persons – A managed care entity may not knowingly have a person who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non procurement activities as a director, officer, partner, or person with beneficial ownership of more than 5% of the entity's equity, or have an employment, consulting, or other agreement for the provision of items and services that are significant and material to the entity's obligations under its contract with the State.

g. Business Transactions – The MCO which is not federally qualified must disclose to the Department information on certain types of transactions they have with a "party in interest" as defined in the Public Health Service Act. (See Sections 1903(m)(2)(A)(viii) and 1903(m)(4) of the Act.)

1) Definition of a Party in Interest – As defined in Section 1318(b) of the Public Health Service Act, a party in interest is:

a) Any director, officer, partner, or employee responsible for management or administration of the MCO; any person who is directly or indirectly the beneficial owner of more than 5% of the equity of the MCO; any person who is the beneficial owner of

more than 5% of the MCO; or, in the case of the MCO organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law;

b) Any organization in which a person described in Subsection 1 is director, officer or partner; has directly or indirectly a beneficial interest of more than 5% of the equity of the MCO; or has a mortgage, deed of trust, note, or other interest valuing more than 5% of the assets of the MCO;

c) Any person directly or indirectly controlling, controlled by, or under common control with the MCO; or

d) Any spouse, child, or parent of an individual described in Subsections 1, 2, or 3.

2) Types of Transactions That Must Be Disclosed – Business transactions that must be disclosed include:

a) Any sale, exchange or lease of any property between the MCO and a party in interest.

b) Any lending of money or other extension of credit between the MCO and a party in interest.

c) Any furnishing for consideration of goods, services (including management services) or facilities between the MCO and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.

3) Information Which Must Be Disclosed – The information which must be disclosed in the transactions listed in this subsection between the MCO and a party in interest includes:

a) The name of the party in interest for each transaction.

b) A description of each transaction and the quantity or units involved.

c) The accrued dollar value of each transaction during the fiscal year.

d) Justification of the reasonableness of each transaction.

4) If this Medicaid/MCO contract is being renewed or extended, the MCO must disclose information on these business transactions which occurred during the prior contract period. If the contract is an initial contract with Medicaid, but the MCO has operated previously in the commercial or Medicare markets, information on business transactions for the entire year

preceding the initial contract period must be disclosed. The business transactions which must be reported are not limited to transactions related to serving the Medicaid enrollment. All of these MCO business transactions must be reported.

5) Subcontracts with Providers Experienced with Disabilities – The MCO will subcontract with providers with knowledge and experiences relevant to the needs of the disabled population. This includes subcontracting with at least one (1) mental health/substance abuse provider who specializes in the needs of disabled.

6) Subcontract Termination/Modification – MCO shall notify Department within seven (7) days of any notice by the MCO to a subcontractor, or any notice to the MCO from a subcontractor, of a subcontract termination, a pending subcontract termination, or a pending modification in subcontract terms, that could reduce Medicaid enrollee access to care.

   If the Department determines that a pending subcontract termination or pending modification in subcontract terms will jeopardize enrollee access to care, then the Department may invoke the remedies provided for in this contract. These remedies include contract termination (notice to MCO and opportunity to correct are provided for), suspension of new enrollment, and giving enrollees an opportunity to enroll in a different MCO.

7) The MCO shall submit MOUs referred to in this contract to the Department upon the Department's request.

8) The MCO shall submit to the Department copies of new MOUs, or changes in existing MOUs within 15 days of signing.

ADDENDUM II

CONTRACT SPECIFIED REPORTING REQUIREMENTS

A. Reports and Due Dates

Due Date*	Type of Report	Reporting Period	Due to	Report Format	Reporting Unit	Contract Reference
Within 15 days of contract signing	Civil Rights Compliance Plan: Affirmative Action Plan and Civil Rights Plan Components	Contract period	DHFS		AA/CRC Compliance Office	Art. III, O 1 and 2
Within 30 days of contract signing	Disclosure Statements	As of present time	BMHCP			Add. I, 8
YEAR 2006						
May 1	Electronic list of MCO Providers	Quarterly	Enrollment Broker	Agreed Upon	MCO Service Area	Add 1, 7, f
Jun 1	Encounter Data File**	May – 2006	Medicaid Fiscal Agent MEDS	Electronic Media	Entire MCO	Art. VI, B 2 and G
Jul 1	Encounter Data File**	Jun – 2006	Medicaid Fiscal Agent MEDS	Electronic Media	Entire MCO	Art. VI, B 2 and G
Jul 15	Dental Progress Report	Apr - Jun 2006	BMHCP	Hardcopy	Service Area	Art. III, B 10 d, and Art. VI, B 4
Jul 31	Formal/Informal Grievance Experience Summary Report	Apr – Jun 2006	BMHCP	Hardcopy	Entire MCO	Art. VI, B 3 Art. VIII, F Add. XIII
Aug 1	Electronic list of MCO Providers	Quarterly	Enrollment Broker	Agreed Upon	MCO Service Area	Add 1, 7, f
Aug 1	Encounter Data File**	Jul – 2006	Medicaid Fiscal Agent MEDS	Electronic Media	Entire MCO	Art. VI, B 2 and G
Aug 1	AIDS/Ventilator Dependent	Apr – Jun 2006	BMHCP	Hardcopy & Disc	Entire MCO	Art. V, I 4 Art. VI, B 5 Add. II, D
Aug 15	Federally Qualified Health Centers	Apr – Jun 2006	BMHCP	Hardcopy/no form	By FQHC	Art. III, CC Art. VI, B 7
Aug 15	Coordination of Benefits Report	Apr – Jun 2006	BMHCP	Hardcopy	Entire MCO	Art. VI, B 1 and Add. V
Sep 1	Encounter Data File**	Aug – 2006	Medicaid Fiscal Agent MEDS	Electronic Media	Entire MCO	Art. VI, B 2 and G
Oct 1	Encounter Data File**	Sep – 2006	Medicaid Fiscal Agent MEDS	Electronic Media	Entire MCO	Art. VI, B 2 and G
Oct 15	Dental Progress Report	Jul - Sep 2006	BMHCP	Hardcopy	Service Area	Art. III, B 10 d, and Art. VI, B 4
Oct 31	Formal/Informal Grievance Experience Summary Report	Jul – Sep 2006	BMHCP	Hardcopy	Entire MCO	Art. VI, B 3 Art. VIII, F Add. XIII
Nov 1	Encounter Data File**	Oct – 2006	Medicaid Fiscal Agent MEDS	Electronic Media	Entire MCO	Art. VI, B 2 and G
Nov 1	AIDS/Ventilator Dependent	Jul – Sep 2006	BMHCP	Hardcopy & Disc	Entire MCO	Art. V, I 4 Art. VI, B 5 Add. II, D

Due Date*	Type of Report	Reporting Period	Due to	Report Format	Reporting Unit	Contract Reference
Nov 15	Federally Qualified Health Centers	Jul – Sep 2006	BMHCP	Hardcopy/no form	By FQHC	Art. III, CC Art. VI, B 7
Nov 15	Coordination of Benefits Report	Jul – Sep 2006	BMHCP	Hardcopy	Entire MCO	Art. VI, B 1 and Add. V
Dec 1	Electronic list of MCO Providers	Quarterly	Enrollment Broker	Agreed Upon	MCO Service Area	Add 1, 7, f
Dec 1	Encounter Data File**	Nov – 2006	Medicaid Fiscal Agent MEDS	Electronic Media	Entire MCO	Art. VI, B 2 and G
YEAR 2007						
Jan 1	Encounter Data File**	Dec – 2006	Medicaid Fiscal Agent MEDS	Electronic Media	Entire MCO	Art. VI, B 2 and G
Jan 15	Dental Progress Report	Oct - Dec 2006	BMHCP	Hardcopy	Service Area	Art. III, B 10 d, and Art. VI, B 4
Jan 31	Formal/Informal Grievance Experience Summary Report	Oct - Dec 2006	BMHCP	Hardcopy	Entire MCO	Art. VI, B 3 Art. VIII, F Add. XIII
Jan 31	Provider List	Dec. 31, 2006	BMHCP	Disc	Service Area	Add. III, C
Feb 1	Encounter Data File	Jan – 2007	Medicaid Fiscal Agent MEDS	Electronic Media	Entire MCO	Art. VI, B 2 and G
Feb 1	AIDS/Ventilator Dependent	Oct – Dec 2006	BMHCP	Hardcopy & Disc	Entire MCO	Art. V, I 4 Art. VI, B 5 Add. II, D
Feb 15	Coordination of Benefits Report	Oct – Dec 2006	BMHCP	Hardcopy	Entire MCO	Art. VI, B 1 and Add. V
Feb 15	Federally Qualified Health Centers	Oct – Dec 2006	BMHCP	Hardcopy/no form	By FQHC	Art. III, CC Art. VI, B 7
Mar 1	Electronic list of MCO Providers	Quarterly	Enrollment Broker	Agreed Upon	MCO Service Area	Add 1, 7, f
Mar 1	Encounter Data File**	Feb – 2007	Medicaid Fiscal Agent MEDS	Electronic Media	Entire MCO	Art. VI, B 2 and G
Apr 1	Encounter Data File**	Mar 2007	Medicaid Fiscal Agent MEDS	Electronic Media	Entire MCO	Art. VI, B 2 and G
Apr 15	Dental Progress Report	Jan - Mar 2007	BMHCP	Hardcopy	Service Area	Art. III, B 10 d, and Art. VI, B 4
Apr 30	Formal/Informal Grievance Experience Summary Report	Jan - Mar 2007	BMHCP	Hardcopy	Entire MCO	Art. VI, B 3 Art. VIII, F Add. XIII
May 1	Encounter Data File**	Apr – 2007	Medicaid Fiscal Agent MEDS	Electronic Media	Entire MCO	Art. VI, B 2 and G
May 1	AIDS/Ventilator Dependent	Jan – Mar 2007	BMHCP	Hardcopy & Disc	Entire MCO	Art. V, I 4 Art. VI, B 5 Add. II, D
May 15	Coordination of Benefits Report	Jan - Mar 2007	BMHCP	Hardcopy	Entire MCO	Art. VI, B 1 and Add. V
May 15	Federally Qualified Health Centers	Jan - Mar 2007	BMHCP	Hardcopy/no form	By FQHC	Art. III, CC Art. VI, B 7
Jun 1	Electronic list of MCO Providers	Quarterly	Enrollment Broker	Agreed Upon	MCO Service Area	Add 1, 7, f
Jun 1	Encounter Data File**	May – 2007	Medicaid Fiscal Agent MEDS	Electronic Media	Entire MCO	Art. VI, B 2 and G
Jul 1	Encounter Data File**	Jun 2007	Medicaid Fiscal Agent MEDS	Electronic Media	Entire MCO	Art. VI, B 2, and G
Jul 15	Dental Progress Report	Apr – Jun 2007	BMHCP	Hardcopy	Entire MCO	Art. III, B 10 d, and Art. VI, B 4

Due Date*	Type of Report	Reporting Period	Due to	Report Format	Reporting Unit	Contract Reference
Jul 31	Formal/Informal Grievance Experience Summary Report	Apr – Jun 2007	BMHCP	Hardcopy	Entire MCO	Art. VI, B 3 Art. VIII, F Add. XIII
Aug 1	Encounter Data File**	Jul – 2007	Medicaid Fiscal Agent MEDS	Electronic Media	Entire MCO	Art. VI, B 2, and G
Aug 1	AIDS/Ventilator Dependent	Apr – Jun 2007	BMHCP	Hardcopy & Disc	Entire MCO	Art. V, I 4 Art. VI, B 5 Add. II, D
Aug 15	Federally Qualified Health Centers	Apr – Jun 2007	BMHCP	Hardcopy/no form	By FQHC	Art. III, CC Art. VI, B 7
Aug 15	Coordination of Benefits Report	Apr – Jun 2007	BMHCP	Hardcopy	Entire MCO	Art. VI, B 1 and Add. V
Sept 1	Electronic list of MCO Providers	Quarterly	Enrollment Broker	Agreed Upon	MCO Service Area	Add 1, 7, f
Sep 1	Encounter Data File**	Aug – 2007	Medicaid Fiscal Agent MEDS	Electronic Media	Entire MCO	Art. VI, B 2, and G
Oct 1	Performance Improvement Projects (One PIP required in 2006 which may utilize baseline data for future studies.)	July 2006 – July 2007	BMHCP	Hardcopy	Per Improvement Project	Art. III, S 13
Oct 1	Encounter Data File**	Sep 2007	Medicaid Fiscal Agent MEDS	Electronic Media	Entire MCO	Art. VI, B 2, and G
Oct 15	Dental Progress Report	Jul - Sep 2007	BMHCP	Hardcopy	Service Area	Art. III, B 10 d, and Art. VI, B 4
Oct 31	Formal/Informal Grievance Experience Summary Report	Jul – Sep 2007	BMHCP	Hardcopy	Entire MCO	Art. VI, B 3 Art. VIII, F Add. XIII
Nov 1	Encounter Data File**	Oct – 2007	Medicaid Fiscal Agent MEDS	Electronic Media	Entire MCO	Art. VI, B 2, and G
Nov 1	AIDS/Ventilator Dependent	Jul – Sep 2007	BMHCP	Hardcopy & Disc	Entire MCO	Art. V, I 4 Art. VI, B 5 Add. II, D
Nov 15	Federally Qualified Health Centers	Jul – Sep 2007	BMHCP	Hardcopy/no form	By FQHC	Art. III, CC Art. VI, B 7
Nov 15	Coordination of Benefits Report	Jul – Sep 2007	BMHCP	Hardcopy	Entire MCO	Art. VI, B 1 and Add. V
Dec 1	Electronic list of MCO Providers	Quarterly	Enrollment Broker	Agreed Upon	MCO Service Area	Add 1, 7, f
Dec 1	Encounter Data File**	Nov – 2007	Medicaid Fiscal Agent MEDS	Electronic Media	Entire MCO	Art. VI, B 2, and G

* Any reports that are due on a weekend or holiday are due the following business day.
** MCO may submit encounter data more frequently than monthly after notification and approval by the Department.

Report Mailing Addresses:

Medicaid Fiscal Agent – MEDS
10 E. Doty Street, Suite 210
Madison, WI 53703

BMHCP
Division of Health Care Financing
P.O. Box 309
Madison, WI 53701-0309

B. Wisconsin Medicaid SSI-MCO Summary And Encounter Data Set

MCO that contracts with the DHFS to provide Medicaid services must submit monthly encounter data files according to the specifications and submission protocols published in the Wisconsin Medicaid Encounter Data User Manual.

1. Reporting Requirements

   Encounter data should be reported using the following specifications:

   a. The rules governing the level of detail when reporting encounters should be those rules established by the following classification schemes. ICD-9-CM or ICD-10-CM diagnosis codes and procedure codes, CPT procedure codes (HCPCS Level I codes, Level II HCPCS codes, Level III HCPCS codes), National Drug Codes (NDC), CDT-2 codes, hospital revenue codes for inpatient and outpatient hospital services, and hospital inpatient Diagnostic Related Group (DRG) codes.

   b. Multiple encounters can occur between a single provider and a single enrollee on a day. For example, if a physician provides a limited office visit, administers an immunization, and takes a chest x-ray, and the provider submits a claim or report specifically identifying all three (3) services, then there are three (3) encounters, and the MCO will report three (3) encounters to the Wisconsin Medicaid program.

2. Primary MCO Contract Person

   MCO must specify to the DHFS the name of the primary contact person assigned responsibility for submitting and correcting MCO encounter and utilization data, and a secondary contact person that should be contacted in the event the primary contact person is not available.

3. MCO Encounter Technical Workgroup Requirement

   The MCO must assign staff to participate in MCO encounter technical workgroup meetings periodically scheduled by the Department. This workgroup's purpose is to enhance the MCO Medicaid data submission protocols and improve the accuracy in completeness of the data. The MCO encounter technical workgroup is also responsible for planning the implementation of the 820 and 834 electronic transaction formats mandated by the Health Insurance Portability and Accountability Act (HIPAA).

4. Encounter Data Completeness and Accuracy

   The Department will conduct data validity and completeness audits during the contract period. At least one (1) of these audits will include a review of the MCO's encounter data system and system logic.

5. Analysis of Encounter Data

   The Department retains the right to analyze encounter data used for any purpose it deems necessary. However, the Department will make every effort to ensure that the analysis does not violate the integrity of the reported data submitted by the MCO.

All MCO subcontracts with providers must have provisions for assuring that the data required on the SSI-MCO Utilization Report is reported to the SSI-MCO by the subcontractor. For example, subcontracts with providers of mental health or dental services must have a provision ensuring that survey and encounter data is reported to the SSI-MCO in an accurate and timely fashion.

The Department agrees to involve the SSI-MCO in the planning process prior to implementing any changes in questions or measures, format and definitions, and will request the SSI-MCO to review and comment on those changes before they go into effect.

C. Provider List Requirement

MCO under contract with the Department to provide Medicaid services must submit provider data once per contract period, based on the MCO's files as of December 31, 2005. The data must be provided in a Microsoft Access database by January 31, 2006. A CD containing the database with instructions for the required fields will be provided by the Department by November 15, 2005.

D. AIDS and Ventilator Dependent Enrollee Quarterly Report Form and Detail Report Format

AIDS COST SUMMARY

MCO NAME:_____

Report Period:_____

Number of Cases Reported:_____

Category of Service	Amount Billed	Amount Paid
Inpatient		
Outpatient		
Physician		
Pharmacy		
All Other		
Total		

VENTILATOR COST SUMMARY

MCO Name:_____

Report Period:_____

Number of Cases Reported:_____

Category of Service	Amount Billed	Amount Paid
Inpatient		
Outpatient		
Physician		
Pharmacy		
All Other		
Total		

AIDS and Ventilator Dependent Detail Report

The detail report must be provided on disk and must be in the following layout:

	Field Name	Type	Width	Dec	Position	Explanation
1.	MCO_ID	Num	8	0	1-8	Right justified (MCO Service Area Provider Number)
2.	MA_ID	Num	10	0	9-18	Enrollee Medicaid ID
3.	LNAME	Char	13		19-31	Enrollee Last Name – Left justified
4.	FNAME	Char	10		32-41	Enrollee First Name - Left justified
5.	ELIG_CODE	Char	1		42	A = AIDS; N = NICU vent dependent; V = Vent dependent, non-NICU
6.	DOB	Date	6		43-50	Mmddyyyy
7.	SEX	Char	1		51	F or M
8.	PROV_ID	Num	8	0	52-59	Medicaid Provider Number
9.	PROV LNAME	Char	13		60-72	Medicaid Provider Last Name – Left Justified
10.	PROV FNAME	Char	10		73-82	Medicaid Provider First Name – Left Justified
11.	FROM_DATE	Date	6		83-90	Mmddyyyy
12.	TO_DATE	Date	6		91-98	Mmddyyyy
13.	DIAG_1	Char	5		99-103	Left justified, ICD-9, implied decimal
14.	DIAG_2	Char	5		104-108	Left justified, ICD-9, implied decimal
15.	QTY	Num	4	0	109-112	Right justified (do not zero fill)
16.	PROC_CODE	Char	5		113-117	Left justified, CPT-4, UB92
17.	PROC_DESC	Char	10		118-127	
18.	DRUG_CODE	Num	11	0	128-138	National drug code
19.	DRUG DESC	Char	10		139-148	Drug Name – Left Justified
20.	AMT_BILL	Num	9	2	149-157	Include decimal (do not zero fill)
21.	AMT-PAID	Num	9	2	158-166	Include decimal (do not zero fill)
22.	ADMIT_DATE	Date	8		167-174	Hospital admission date: mmddyyyy
23.	DIS_DATE	Date	8		175-182	Hospital discharge date: mmddyyyy

ADDENDUM III

STANDARD ENROLLEE HANDBOOK LANGUAGE
INTERPRETER SERVICES

This handbook is available in English. For help understanding this information, please call the Customer Service Department at [1-800-xxx-xxxx].

Este manual esta disponible en espanol. Si Ud. quisiera ayuda para entender esta información, por favor llame al Departamento de Servicios para Consumidores, al número [1-800-xxx-xxxx].

Phau ntawv no muaj ua lus mcoob. Yog koj xav tau kev pab kom koj to taub zoo daim ntawv los yog cov xov ntawm no, koj hu tau rau Customer Service Department tus xov tooj [1-800-xxx-xxxx].

IMPORTANT [MCO NAME] TELEPHONE NUMBERS:

Customer Service	[1-800-xxx-xxxx]	[Hours/Days Available]
Emergency Number	[1-800-xxx-xxxx]	Call 24 hours a day, seven (7) days a week
TDD/TTY	[1-800-xxx-xxxx]	

WELCOME

Welcome to [MCO NAME]. As a member of [MCO NAME], you will receive all your health care from [MCO NAME] doctors, hospitals, and pharmacies. See [MCO NAME] Provider Directory for a list of these providers. You may also call our Customer Service Department at [1-800-xxx-xxxx]. Providers not accepting new patients are marked in the Provider Directory.

Care Coordinator – (MCO NAME) matches you with a Care Coordinator to help you with your medical and social service needs. Call your Care Coordinator at (MCO NAME):

- To choose a primary care provider.
- To help you get medical or social services.
- When you have questions about your health care.

Call your Care Coordinator directly or call our CUSTOMER SERVICE OFFICE at ###-####. You can talk to a Care Coordinator 24 hours a day, seven (7) days a week.

YOUR FORWARD ID CARD

Always carry your Forward ID card with you, and show it every time you get care. You may have problems getting care or prescriptions if you do not have your card with you. Also bring any other health insurance cards you may have.

PRIMARY CARE PHYSICIAN (PCP)

It is important to call your primary care physician (PCP) first when you need care. This doctor will manage all your health care. If you think you need to see another doctor, or a specialist, ask your PCP. Your PCP will help you decide if you need to see another doctor, and give you a referral. Remember, you must get approval from your PCP before you see another doctor.

You can choose your primary care physician (PCP) from those available. (NOTE: For women you may also see a women's health specialist [for example a OB/GYN doctor or a nurse midwife] without a referral, in addition to choosing your PCP.) There are MCO doctors who are sensitive to the needs of many cultures. To choose a PCP, or to change to a different PCP, call our Customer Service Department at [1-800-xxx-xxxx].

EMERGENCY CARE

Emergency care is care needed right away. This may be caused by an injury or a sudden illness. Some examples are:

Choking	Severe or unusual bleeding
Trouble breathing	Suspected poisoning
Serious broken bones	Suspected heart attack
Unconsciousness	Suspected stroke
Severe burns	Convulsions
Severe pain	Prolonged or repeated seizures

If you need emergency care, go to a [MCO NAME] provider for help if you can. BUT, if the emergency is severe, go to the nearest provider (hospital, doctor or clinic). You may want to call 911 or your local police or fire department emergency services if the emergency is severe.

If you must go to a [non-MCO NAME] hospital or provider, call [MCO NAME] at [1-800-xxx-xxxx] as soon as you can and tell us what happened. This is important so we can help you get follow up care.

Remember, hospital emergency rooms are for true emergencies only. Call your doctor or our 24-hour emergency number at [1-800-xxx-xxxx] before you go to the emergency room, unless your emergency is severe.

URGENT CARE

Urgent Care is care you need sooner than a routine doctor's visit. Urgent care is not emergency care. Do not go to a hospital emergency room for urgent care unless your doctor tells you to go there. Some examples of urgent care are:

Most broken bones	Minor cuts
Sprains	Bruises
Non-severe bleeding	Most drug reactions
Minor burns	

If you need urgent care, call [insert instructions here-- call clinic, doctor, 24-hour number, nurse line, etc.] We will tell you where you can get care. You must get urgent care from [MCO NAME] doctors unless you get our approval to see a [non-MCO NAME] doctor.

Remember, do not go to a hospital emergency room for urgent care unless you get approval from [MCO NAME] first.

HOW TO GET MEDICAL CARE WHEN YOU ARE AWAY FROM HOME

Follow these rules if you need medical care but are too far away from home to go to your assigned primary care physician (PCP) or clinic.

For severe emergencies, go to the nearest hospital, clinic, or doctor.

For urgent or routine care away from home, you must get approval from us to go to a different doctor, clinic or hospital. This includes children who are spending time away from home with a parent or relative. Call us at [1-800-xxx-xxxx] for approval to go to a different doctor, clinic, or hospital.

PREGNANT WOMEN AND DELIVERIES

You must go to a [MCO NAME] hospital to have your baby. Talk to your [MCO NAME] doctor to make sure you understand which hospital you are to go to when it's time to have your baby.

Also, talk to your doctor if you plan to travel in your last month of pregnancy. Because we want you to have a healthy birth and a good birthing experience, it may not be a good time for you and your unborn child to be traveling. We want you to have a healthy birth and your [MCO Name] doctor knows your history and is the best doctor to help you have a healthy birth. Do not go out of area to have your baby unless you have your doctor's approval.

WHEN YOU MAY BE BILLED FOR SERVICES

It is very important to follow the rules when you get medical care so you are not billed for services. You must receive your care from [MCO NAME] providers, hospitals, and pharmacies unless you have our approval. The only exception is for severe emergencies.

If you travel outside of Wisconsin and need emergency services, health care providers can treat you and send claims to (MCO NAME). You will have to pay for any service you get outside Wisconsin if the health care provider refuses to submit claims or refuses to accept (MCO NAME) payment as payment in full.

(MCO NAME) does not cover any service, including emergency services, provided outside of the United States, Canada and Mexico.

IF YOU ARE BILLED

If you receive a bill for services, call our Customer Service Department at [1-800-xxx-xxxx]. You do not have to pay for services that [MCO NAME] is required to provide you.

OTHER INSURANCE

If you have other insurance in addition to [MCO NAME], you must tell your doctor or other provider. Your health care provider must bill your other insurance before billing [MCO NAME]. If your [MCO NAME] doctor does not accept your other insurance, call the MCO Enrollment Specialist at 1-800-291-2002. The Enrollment Specialist can tell you how to match your MCO enrollment with your other insurance so you can use both insurance plans.

SERVICES COVERED BY [MCO NAME]

[MCO NAME] provides all medically necessary covered services. Some services may require a doctor's order or a prior authorization. Covered services include:

- Prescription drugs and certain over-the counter drugs when ordered by a doctor
- Services by doctors and nurses, including nurse practitioners and nurse midwives
- Inpatient and outpatient hospital services
- Laboratory and X-ray services
- HealthCheck for members under 21 years of age, including referral for other medically necessary services
- Certain podiatrists' (foot doctors) services
- Inpatient care at institutions for mental disease (care for persons 22-64 years of age is not included)
- Optometrists' (eye doctors) or opticians' services, including eyeglasses
- Mental health treatment
- Substance abuse (drug and alcohol) services
- Family planning services and supplies
- The following services when a doctor gives a written order:
    - Prostheses and other corrective support devices
    - Hearing aids and other hearing services
    - Home health care
    - Personal care
    - Independent nursing services
    - Medical supplies and equipment
    - Occupational therapy

- Physical therapy
- Speech therapy
- Respiratory therapy
- Nursing home services
- Medical Nutrition Counseling
- Hospice care
- Appropriate transportation to obtain medical care by ambulance or specialized medical vehicles

- Certain dental services (not all dental services are covered) [Eliminate if MCO does not provide dental]
- Certain chiropractic services [Eliminate if MCO does not provide chiropractic]

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

[MCO NAME] provides mental health and substance abuse (drug and alcohol) services to all enrollees. If you need these services, call [PCP, gatekeeper, Customer Service, as appropriate].

FAMILY PLANNING SERVICES

We provide confidential family planning services to all enrollees. If you do not want to talk to your primary care doctor about family planning, call our Customer Service Department at [1–800-xxx-xxx]. We will help you choose a [MCO NAME] family planning doctor who is different from your primary care doctor.

You can also go to any family planning clinic that will accept your Forward ID card even if the clinic is not part of [MCO NAME]. But we encourage you to receive family planning services from a [MCO NAME] doctor. That way we can better coordinate all your health care.

DENTAL SERVICES

[Note to MCO: Use statement (1) if you provide dental services. Use statement (2) if you do not provide dental services. If you provide dental services in only part of your service area, use both statements and list the appropriate counties with each statement.]

1. [MCO NAME] provides all covered dental services. But you must go to a [MCO NAME] dentist. See the Provider Directory or call the Customer Service Department at [1-800-xxx-xxxx] for the names of our dentists.

2. You may get dental services from any dentist who will accept your Forward ID card. Your dental services are provided by the State, not [MCO NAME]. If you are enrolled in the State dental managed care program, you must get your dental services from that program.

CHIROPRACTIC SERVICES

[Note to MCO: Use statement (1) if you provide chiropractic services. Use statement (2) if you do not provide chiropractic services.]

1. [MCO NAME] provides covered chiropractic services. But you must go to a [MCO NAME] chiropractor. See the Provider Directory or call the Customer Service Department at [1-800-xxx-xxxx] for the names of our chiropractors.

2. You may get chiropractic services from any chiropractor that will accept your Forward ID card. Your chiropractic services are provided by the State, not [MCO NAME].

HEALTHCHECK

HealthCheck is a preventive health checkup program for enrollees under the age of 21. The HealthCheck program covers complete health checkups. These checkups are very important for the health of enrollees under the age of 21. The doctor wants to see those under 21 for regular checkups, not just when they are sick.

The HealthCheck health program has three (3) purposes:

1. To identify and treat health problems early for those under 21.

2. To provide information about special health services for those under 21.

3. To qualify those under 21 for health care services not otherwise covered.

The HealthCheck program covers the care for any health problems found during the checkup including medical care, eye care and dental care.

The HealthCheck checkup includes:

- A health history.
- Physical exam.
- Developmental assessment.
- Hearing and vision test.
- Blood and urine lab tests.
- Complete immunizations (shots).

Those who are 19 and 20 years old will be referred to a dentist under HealthCheck. Help in choosing and getting to a dentist will be provided by calling the Customer Care Department at [1-800-xxx-xxxx].

[MCO NAME] will help arrange for transportation for HealthCheck visits. Call our Customer Service Department a [1-800-xxx-xxxx].

To schedule a HealthCheck exam or for more information on HealthCheck, call our Customer Service Department at [1-800-xxx-xxxx].

TRANSPORTATION

(Note to MCO: Use statement (1) if you arrange transportation for your enrollees. Use statement (2) if you do not arrange transportation for your enrollees. Use statement (3) if you arrange transportation in only part of your service area.

1. Bus or taxi rides to receive care are arranged by [MCO NAME]. Call our Customer Service Department at [1-800-xxx-xxxx] if you need a ride.

2. Bus or taxi rides to receive care are arranged by your county Department of Social or Human Services. Call them for information.

3. Bus or taxi rides to receive care are arranged by [MCO NAME] if you live in [INSERT COUNTIES]. Call our Customer Service Department at [1-800-xxx-xxxx] if you need a ride. If you live in a county that is not listed please call your county Department of Social or Human Services for information about arranging a ride.

AMBULANCE

[MCO NAME] covers ambulance service for emergency care. We may also cover this service at other times, but you must have approval for all non-emergency ambulance trips. Call our Customer Service Department at [1-800-xxx-xxxx] for approval.

SPECIAL MEDICAL VEHICLE (SMV)

[MCO NAME] covers transportation by special vehicle for those in wheelchairs. We may also cover this service for others if your doctor asks for it. Call our Customer Service Department at [1-800-xxx-xxxx] if you need this service.

IF YOU MOVE

If you are planning to move, contact your county Department of Social or Human Services. If you move to a different county, you must also contact the Department of Social or Human Services in your new county to update your eligibility. If you move out of [MCO NAME'S] service area, call the MCO Enrollment Specialist at 1-800-291-2002. [MCO NAME] will only provide emergency care if you move out of our service area.

HEALTH INSURANCE AFTER YOUR ELIGIBILITY ENDS

You have the right to purchase a private health insurance policy from [MCO NAME] when your eligibility ends. Call our Customer Service Department at [1-800-xxx-xxxx]. If you decide to purchase a policy from us, you have 30 days after the date your eligibility ends to apply.

MCO EXEMPTIONS

An MCO exemption means that you are not required to join an MCO to receive your health care benefits. Most exemptions are granted for only a short period of time so you can complete a course of treatment before you are enrolled in an MCO. If you think you need an exemption from MCO enrollment, call the MCO Enrollment Specialist at 1-800-291-2002 for more information.

SECOND MEDICAL OPINION

A second medical opinion on recommended surgeries may be appropriate in some cases. Contact your doctor or our Customer Service Department for information.

LIVING WILL OR POWER OF ATTORNEY FOR HEALTH CARE

You have a right to make decisions about your medical care. You have a right to accept or refuse medical or surgical treatment. You also have the right to plan and direct the types of health care you may receive in the future if you become unable to express your wishes. You can let your doctor know about your feelings by completing a living will or power of attorney for health care form. Contact your doctor for more information.

RIGHT TO MEDICAL RECORDS

You have the right to ask for copies of your medical record from your provider(s). We can help you get copies of these records. Please call [1-800-xxx-xxxx] for help. Please note: You may have to pay to copy your medical records. You also may correct wrong information in your medical records if your doctor agrees to the correction.

[MCO NAME'S] MEMBER ADVOCATE

[MCO NAME] has a Member Advocate to help you get the care you need. The Advocate can answer your questions about getting health care from [MCO NAME]. The Advocate can also help you solve any problems you may have getting health care from [MCO NAME]. You can reach the Advocate at [1-800-xxx-xxxx].

STATE OF WISCONSIN MCO OMBUDS PROGRAM

The State has Ombuds who can help you with any questions or problems you have as an MCO enrollee. The Ombuds can tell you how to get the care you need from your MCO. The Ombuds can also help you solve problems or complaints you may have about the MCO Program or your MCO. Call 1-800-760-0001 and ask to speak to an Ombud.

COMPLAINTS AND GRIEVANCES

We would like to know if you have a complaint about your care at [MCO NAME]. Please call [MCO NAME'S] Member Advocate at [1-800-xxx-xxxx] if you have a complaint. Or you can write to us at:

[MCO name and mailing address]

If you want to talk to someone outside of [MCO NAME] about the problem, call the MCO Enrollment Specialist at 1-800-291-2002. The Enrollment Specialist may be able to help you solve the problem, or can help you write a formal grievance to [MCO NAME] or to the Wisconsin Managed Care program.

To file a grievance with the Wisconsin Managed Care program contact:

MCO Ombuds
P.O. Box 6470
Madison, WI 53716

We cannot treat you differently than other members because you file a complaint. Your health care benefits will not be affected.

You have the right to appeal to the State of Wisconsin Division of Hearings and Appeals for a Fair Hearing if you believe your benefits are unfairly denied, limited, reduced, delayed or stopped by [MCO NAME]. An appeal must be made no later than 45 days after the date of the action being appealed. If you appeal this action to DHA before the effective date, the service may continue. You may need to pay for the cost of services if the hearing decision is not in your favor.

If you want a Fair Hearing, send a written request to:

Department of Administration
Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875

The hearing will be held in the county where you live. You have the right to bring a friend or be represented at the hearing. If you need a special arrangement for a disability, or for English language translation, please call (608) 266-3096 (voice) or (608) 264-9853 (hearing impaired).

We cannot treat you differently than other members because you request a Fair Hearing. Your health care benefits will not be affected.

If you need help writing a request for a Fair Hearing, please call:

Wisconsin Managed Care Ombudsman:	1-800-760-0001, or
MCO Enrollment Specialist:	1-800-291-2002

PHYSICIAN INCENTIVE PLAN

You are entitled to ask if we have special financial arrangements with our physicians that can affect the use of referrals and other services you might need. To get this information, call our Customer Service Department at [1-800-xxx-xxxx] and request information about our physician payment arrangements.

PROVIDER CREDENTIALS

You have the right to information about our providers that includes the provider's education, Board certification and recertification. To get this information, call our Customer Service Department at [1-800-xxx-xxxx].

MEMBER RIGHTS

You have the right to ask for an interpreter and have one provided to you during any Medicaid-covered service.

You have the right to receive the information provided in this member handbook in another language or another format.

You have the right to receive health care services as provided for in Federal and State law. All covered services must be available and accessible to you. When medically appropriate, services must be available 24 hours a day, seven (7) days a week.

You have the right to receive information about treatment options including the right to request a second opinion.

You have the right to make decisions about your health care.

You have the right to be treated with dignity and respect.

You have the right to be free from any form of restraint or seclusion used as a means of force, control, ease or reprisal.

YOUR CIVIL RIGHTS

[MCO NAME] provides covered services to all eligible members regardless of:

- Age
- Race
- Religion
- Color
- Disability
- Sex
- Sexual Orientation
- National Origin
- Marital Status
- Arrest or Conviction Record
- Military Participation

All medically necessary covered services are available to all members.

All services are provided in the same manner to all members.

All persons or organizations connected with [MCO Name] who refer or recommend members for services shall do so in the same manner for all members.

Translating or interpreting services are available for those members who need them. This service is free.

ADDENDUM IV

COB REPORT FORMAT

STATE OF WISCONSIN MEDICAID MCO
REPORT ON COORDINATION OF BENEFITS

Instructions for completing the form on page:

In order to comply with CMS reporting requirements, the MCO must submit to the Department a Quarterly Coordination of Benefits (COB) report for their entire service area, aggregating all separate service areas if the MCO has more than one service area. The report must include subrogation collections from auto, homeowners, or malpractice insurance, restitution payments from the Division of Corrections, or collections from Worker's Compensation.

For the purposes of this report, the MCO enrollee is any Medicaid recipient listed as an ADD or CONTINUE on the monthly MCO enrollment report(s) that are generated by the Department's Medicaid fiscal agent.

The COB report must be submitted to the Department's fiscal agent within 45 days of the end of the quarter being reported.

Mail to: Medicaid Fiscal Agent
Managed Care Unit
P.O. Box 6470
Madison, WI 53716-0470

Or Fax to: Medicaid Fiscal Agent
Attn: Managed Care Unit
(608) 224-6318

STATE OF WISCONSIN
MEDICAID/BADGERCARE
MCO REPORT ON COORDINATION OF BENEFITS

Name of MCO:_____ Mailing Address:_____

Office Telephone:_____ _____

Provider Number:_____ _____

Please designate below the quarter period for which information is given in this report.

_____, 20____ through _____, 20____

A. <u>Cost Avoidance</u>

Cost avoidance includes dollar amounts denied as a result of a third party insurer paying the bill. Therefore, the MCO denied the claim.

1. Amount Cost Avoided:_____

B. <u>Recoveries (Post-Pay Billing/Pay and Chase)</u>

1. Dollar amount recovered as a result of billing an enrollee's other insurance.

   a. Other Insurance:_____
   b. Subrogation/Worker's Compensation:_____

2. Dollar amount of other recoveries:_____ (i.e., legal action, estate recoveries or any other recoveries that are not specifically noted above.)

I HEREBY CERTIFY that to the best of my knowledge and belief, the information contained in this report is a correct and complete statement prepared from the records of the MCO, except as noted on the report.

Signed:_____
Original Signature of Director or Administrator

Title:_____

Date Signed:_____

ADDENDUM V

MODEL MEMORANDUM OF UNDERSTANDING
MANAGED CARE ORGANIZATION
AND
PRENATAL CARE COORDINATION AGENCY

Prenatal care coordination (PNCC) services are paid FFS by the Wisconsin Medicaid program for all recipients, including those enrolled in MCOs. The PNCC agencies are responsible for services that include outreach, risk assessment, care planning, care coordination and follow-up to support high-risk pregnant women. The MCO is responsible for providing and managing medically necessary services. Successful provision of the services to individual recipients requires cooperation, coordination and communication between the MCO and PNCC.

The MCO and PNCC agree to facilitate effective communication between agencies, work to resolve inter-agency coordination and communication problems, and inform staff from both MCO and PNCC about the policies and procedures for this cooperation, coordination and communication.

Recognizing that these "clients-in-common" are at high risk for poor birth outcomes, the MCO and PNCC agree to cooperate in removing access barriers, coordinating care and providing culturally competent services.

This agreement becomes effective on the date the PNCC is certified by WISCONSIN MEDICAID or on the date when both MCO and PNCC have signed, whichever is later. It may be terminated in writing with two (2) week's notice by either signer.

MCO	**PNCC**
Authorizing Signature	Authorizing Signature
Printed Name	Printed Name
Title	Title
Date	Date

ADDENDUM VI

HEALTHCHECK WORKSHEET

MCO:_____ MCO Provider Number for County:_____

		Calculation	Age Group 19 – 20
1	Number of eligible months for enrollees age 19 through age 20.	Entered (Total is sum of age groups.)	
2	Number of unduplicated enrollees age 19 through age 20.	Entered	
3	Ratio of recommended screens per age group member.	Given	0.50
4	Average period of eligibility (in years).	Line 1 ÷ Line 2 ÷12 (Total Is calculated by formula.)	
5	Adjusted ratio of recommended screens per age group member.	Line 3 x Line 4	
6	Expected number of screens (100% of required screens for ages and months of eligibility).	Line 2 x Line 5 (Total is sum of age groups.)	
7	Number of screens in goal (80%).	Line 6 x 0.80 (Total is calculated by formula.)	
8	Actual number of screens completed.	Entered (Total is sum of age groups.)	
9	Difference between goal and actual.	Line 8 – Line 7 (Positive result means goal is met; negative result means goal is not met.)	
10	Percent of the FFS equivalent that your MCO is discounted for.		
11	Amount per screen to be recouped.	FFS maximum allowable fee *(Article V. B. 7) x Line 10	
12	Total recoupment.	Line 11 x Line 9	

ADDENDUM VII

MODEL MEMORANDUM OF UNDERSTANDING

MANAGED CARE ORGANIZATION
AND
SCHOOL DISTRICT OR CESA MEDICAID CERTIFIED
FOR THE SCHOOL-BASED SERVICES BENEFIT

School-Based Services (SBS) is a benefit paid FFS by the Wisconsin Medicaid program for all school enrolled recipients, including those enrolled in the MCO. The SBS provider is responsible for services which include occupational/physical/speech therapies, private duty or home care individualized nursing services, mental health services, testing services, school Individual Education Plan (IEP) services, and Individualized Family Service Program (IFSP) services, when provided in the school. The MCO is responsible for providing and managing medically necessary services outside of school settings. However, there are some situations where schools cannot provide services, such as after school hours, during school vacations, and during the summer. Therefore, avoidance of duplication of services and promotion of continuity of care for Medicaid MCO enrollees requires cooperation, coordination and communication between the MCO and the SBS provider.

The MCO and the SBS provider agree to facilitate effective communication between agencies, work to resolve inter-agency coordination and communication problems, and inform staff from both the MCO and the SBS provider about the policies and procedures for this cooperation, coordination and communication. Recognizing that these "clients-in-common" could receive duplicate services and could suffer with problems in continuity of care (e.g., when the school year ends in the middle of a series of treatments), the MCO and the SBS provider agree to cooperate in communicating information about the provision of services and in coordinating care.

This agreement becomes effective on the date the SBS provider is certified by the Wisconsin Medicaid Program or on the date when both the MCO and the SBS provider have signed, whichever is later. It may be terminated in writing with two (2) weeks' notice by either signer. The SBS provider is the School District or the CESA.

School-Based Services Provider	**Dane County Managed Care Organization**
Signature	Signature
Printed Name	Printed Name
Title	Title
Date	Date

ADDENDUM VIII

GUIDELINES FOR THE COORDINATION OF SERVICES BETWEEN MCOS, AND CHILD WELFARE AGENCIES

(The same language will be incorporated as an Appendix in the case management provider handbook, ensuring that both the MCO and case management providers have the same language available to them.)

MCO Rights and Responsibilities

1. The MCO must designate at least one (1) individual to serve as a contact person for case management providers. If the MCO chooses to designate more than one (1) contact person, the MCO should identify the target populations for which each contact person is responsible.

2. The MCO may make referrals to case management agencies when they identify an enrollee from an eligible target population who they believe could benefit from case management services.

3. If the enrollee or case manager requests the MCO to conduct an assessment, the MCO will determine whether there are signs and symptoms indicating the need for an assessment. If the MCO finds that assessment is needed, the MCO will determine the most appropriate level for an assessment to be conducted (e.g., primary care physician, specialist, etc.). If the MCO determines that no assessment is needed, the MCO will document the rationale for this decision.

4. The MCO must determine the medical need for those services covered under the MCO contract based on the results of the assessment and the medical necessity of the recommended treatment/services.

5. The MCO case management liaison, or other appropriate staff as designated by the MCO, must participate in case planning with the case management agency, unless no services provided through the MCO are required.

    a. The case planning may be done through telephone contact or means of communication other than attending a formal case-planning meeting.

    b. The MCO must informally discuss differences in opinion regarding the MCO's determination of treatment needs if requested by the enrollee or case manager.

    c. The MCO case management liaison and the case manager must discuss who will be responsible for ensuring that the enrollee receives the services authorized by and provided through the MCO.

    d. The MCO's role in the case planning may be limited to a confirmation of the services the MCO will authorize if the enrollee and case manager determine the services are appropriate.

Case Management Agency Rights and Responsibilities

1. The case management agency is responsible for initiating contact with the MCO to coordinate services for enrollee(s) they have in common and providing the MCO with the name and telephone number(s) of the case manager(s).

2. If the MCO refers an enrollee to the case management agency, the case management agency must conduct an initial screening based on their usual procedures and policies. The case management agency must determine whether or not they will provide case management services and notify the MCO of this decision.

3. The case management agency must complete a comprehensive assessment of the enrollee's needs in accordance with the requirements in the case management provider handbook. This includes a review of the enrollee's physical and dental health needs.

4. If the case management agency requires copies of the enrollee's medical records, the case management agency must obtain the records directly from the service provider(s), not from the MCO.

5. The case manager must identify whether the enrollee has additional service or treatment needs. As a part of this process, the case manager and the enrollee may seek additional assessment of conditions which the MCO may be expected to treat under the terms of its contract, if the MCO determines there is a need for an assessment.

6. The case management agency may not determine the need for specific medical care covered under the MCO contract, nor may the case management agency make referrals directly to specific providers of medical care covered through the MCO.

7. The case manager must complete a comprehensive case plan in accordance with the requirements of the case management provider handbook. The plan must include the medical services the enrollee requires as determined by the MCO.

8. If the case management agency specifically requests the MCO liaison to attend a planning meeting in person, the case management agency must reimburse the MCO for the costs associated with attending the planning meeting. These are allowable costs for case management reimbursement through Wisconsin Medicaid.

   Nothing in these guidelines precludes the MCO and the case management agency from entering into a formal contract or Memorandum of Understanding to address issues not outlined here.

ADDENDUM IX

FORMAL GRIEVANCE EXPERIENCE SUMMARY REPORT

1. Grievances Related to Program Administration

Enrollee Identification Number	Date Grievance Filed	Nature of Grievance	Date Resolved	Summary of Grievance Resolution	Administrative Changes as a Result of Grievance Review

2. Grievances Related to Benefit Denials/Reductions

Enrollee Identification Number	Date Grievance Filed	Nature of Grievance	Date Resolved	Summary of Grievance Resolution	Administrative Changes as a Result of Grievance Review

3. Summary

SUBTOTAL Program Administration: _____
SUBTOTAL Benefit Denials/Reductions: _____
TOTAL NUMBER OF GRIEVANCES: _____

Return the completed form to:

Bureau of Managed Health Care Programs
P.O. Box 309
Madison, WI 53701-0309
Fax (608) 266-7729

4. MCO Reporting Form for Informal Grievances

_____

MCO Name

☐ First Quarter
☐ Second Quarter
☐ Third Quarter
☐ Fourth Quarter
☐ Calendar Year 2004
☐ Calendar Year 2005

TYPE OF INFORMAL GRIEVANCE	TOTAL NUMBER OF GRIEVANCES
1. ACCESS PROBLEMS	
2. BILLING ISSUES	
3. QUALITY OF CARE	
4. DENIAL OF SERVICE	
5. OTHER SPECIFY:	

General Definitions

1. Access problems include any problem identified by the MCO that causes an enrollee to have difficulty getting an appointment, receiving care, or receiving culturally appropriate care, including the provision of interpreter services in a timely manner.

2. Billing issues include the denial of a service or a recipient receiving a bill for a Medicaid covered service that the MCO is responsible for providing or arranging for the provision of that service.

3. Quality of care includes long waiting time in the reception area of providers' offices, rude providers or provider staff, or any other complaint related directly to patient care.

4. Denial of service includes any Medicaid covered service that the MCO denied.

5. Others as identified by the MCO.

Return the completed forms to:

Bureau of Managed Health Care Programs
ATTN: Grievance Contract Specialist
P.O. Box 309
Madison, WI 53701-0309

ADDENDUM X

LOCAL HEALTH DEPARTMENTS AND COMMUNITY-BASED HEALTH ORGANIZATIONS A RESOURCE FOR MCOs

Local Health Departments

Local health departments (LHDs) throughout the state have an essential role in promoting the health of citizens of Wisconsin. They have general and specific statutory authority to prevent disease, promote health and protect the health of the citizens. They work in collaboration with community-based organizations, medical care facilities, and local community agencies to develop and coordinate systems of care so that the public's health can be protected. Specific statutory authority include the three (3) public health core functions of assessment, policy development and assurance.

Assessment

The regular, systematic collection, assembly, analysis and dissemination of information on the health of the community. This includes incidence and prevalence data, and morbidity, mortality and environmental data in areas that include: communicable disease, chronic disease and environmental health.

Policy Development

The exercise of responsibility to serve the public's interest by fostering shared ownership with the community in the development of comprehensive public health plans, programs, services and guidelines.

Assurance

To take reasonable and necessary action to assure citizens that services necessary to achieve public health goals are available. This is done by encouraging the actions of others in the private, public and/or voluntary sectors, and by requiring action through enforcement or by directly providing services.

Description of Public Health Services

LHDs' capacities may vary, however, they are required to provide or assure five (5) basic public health services. These include:

1. Communicable Disease Surveillance.

2. Prevention and Control.

3. Health Promotion.

4. Disease Prevention.

5. Human Health Hazard Control.

6. Generalized Public Health Nursing Programs.

Although LHDs serve the population as a whole, they have established traditions of working with population groups at increased risk of illness, disability and premature death. The following specific services have been delineated with the hope of linking Medicaid Managed Care plans with local heath departments. Linking primary care and public health is an essential strategy to strengthen the health of local communities and thus benefit the population of the state as a whole:

- LHDs have access to population data that may be very useful to the MCO in determining their services and quality studies.

- LHDs closely collaborate their programs with key community agencies that serve the Medicaid population. These include: WIC, PNCC, School Health Services, Birth-to-Three Programs, Family Planning, and Developmental Disabilities.

- LHDs promote and provide health education programs on topics that include: Domestic abuse/violence prevention, smoking cessation, breast Feeding, cardiovascular risk reduction, prenatal/postpartum education, nutrition, and self-care skills.

- LHDs provide health-related home/community inspections in areas that include: Lead poisoning, asbestos, indoor air quality, home safety, and drinking water safety.

- LHDs monitor communicable disease incidence/prevalence, provide information to the public on prevention, conduct epidemiologic investigations of outbreaks/unusual conditions.

Access to Special Populations

Wisconsin's LHDs perform many public health services including the provision of direct services to Medicaid recipients. Some LHDs provide Medicaid reimbursed services for which MCOs may contract, such as:

- HealthCheck screening, outreach and follow-up.

- Immunizations.

- Blood lead screening.

- Targeted case management of medical conditions such as asthma, diabetes, hypertension and children with special health care needs.

- Home health and personal care services.

LHD's provide important resources such as:

- Clinics serving high-risk populations.
- Culturally competent staff experienced in dealing with diverse, high-risk populations.
- Direct access to outreach and follow-up of at-risk population groups in home and community settings.
- Environmental inspection and case management for children with elevated blood lead levels.
- Outreach to assist the MCO to achieve required rates, such as the HealthCheck screening rate.
- Experience in family-centered care.
- Linkages with other community-based providers and advocacy groups.
- Highly skilled staff who emphasize prevention and public health.

Community-Based Health Organizations

Throughout the state, the health care network includes many nonprofit community-based health organizations including: Independent HealthCheck providers, family planning clinics, and WIC clinics. These organizations may provide some of the same Medicaid reimbursed services as LHDs and are an essential element to advance the health of community. They may also have the same access to special populations as LHDs.

Collaboration with Public and Community-Based Health Organizations

The MCO should consider how to utilize the local public health departments and community-based health organizations through:

- Identifying and utilizing the resources they provide; and
- Where appropriate, contracting with LHDs and other community health agencies for Medicaid-reimbursable services.

The complementary roles of managed care and public health are significant and evolving. Communities will be healthier and health care costs will be reduced if health care providers work together. To find out the names of key contacts at LHDs and community-based health organizations in your area, contact your local health department.

ADDENDUM XI

ATTESTATION FORM

I, _____, have reviewed the following data:
(Name and Title)

☐ Encounter Data for _____ quarter 200___.

☐ AIDS/Vent Report

☐ Other _____
(Specify Report)

I hereby attest and affirm that the information being submitted is complete, factual and correct to the best of my knowledge. I furthermore attest and affirm that no material facts have been omitted from this form. I understand that payment and satisfaction of this/these claim(s) will be from federal and state public funds and that I may be prosecuted under applicable federal and state laws for nay false claims, statements, or documents, or concealment of a material fact. I furthermore understand that state or federal authorities may inspect all claims, records or documents pertaining to the provision of these services.

_____ will maintain these claims for a period of five
(MCO Name) (5) years from the date of contract termination.

_____ _____
(Signature) (Date)

_____ _____
(Print Name) (Print Date)

ADDENDUM XII

Rate Development, Risk Adjustment and Funding for Persons Receiving Community Support Program (CSP) or Targeted Case Management (TCM) Services

I. County Matched Services

- The covered services under this contract may include the Medicaid funded services under Community Support Programs and/or Targeted Case Management.

II. Calculation of Payment Rate for County and Federal Share of County Matched Services

a. Payment rates under this contract will be determined based on inclusion of an actuarially sound estimate of the total Medicaid allowable cost of these services for the population used to calculate rates.

b. The estimate of allowable cost will include both Federal Financial Participation (FFP) and funding of the required matching funds previously provided by Dane County.

III. Satisfaction of County Funding Obligation for CSP and TCM for Persons Enrolled in Care Management Organization

a. In order to reflect inclusion of required State or Local matching funds through the monthly capitation rates, the Department will adjust Dane County's Basic County Allocation amount to reflect the amount Dane County would have funded in the absence of the managed care program.

b. The Basic County Allocation adjustment will be made every six months with the first adjustment based on an estimate of the number of CSP and TCM eligible persons to enroll in the managed care program. The final adjustment will be made three months following the close of the contract period based on the prior six month period of enrollment.

c. County funding obligation is only for persons enrolled who are receiving or have received CSP or TCM services within three month of enrolling into the care management organization.

IV. Obligation of Care Management Organization to Provide CSP and TCM Services

- Health Plan for Community Living, (the Care Management Organization) assumes full liability for the cost and provisions of CSP and TCM services for enrollees in their program.

V. Retrospective Case-Mix Reconciliation.

a. The reconciliation will also reflect and adjust for any material difference in intensity of CSP and TCM services between the population enrolled in the managed care program and the remaining county equivalent population.

b. Intensity of services will be measured using a mutually agreed upon risk adjustment system (e.g. Chronic Illness and Disability Payment System).

c. Any additional payment that is due to the care management organization, or that is owed to the county, resulting from the above adjustments, will be limited by the amount that would have been allowed under the Fee-For-Service payment system.

_____(MCO Name) _____

_____(MCO Sig)_____

_____(Date)_____

_____(State Sig)_____

_____(Date)_____

_____(County Sig)_____

_____(Date)_____

ADDENDUM XIII

RISK-SHARING

I. Definitions

a) Direct Member Services – includes those services that directly benefit a member including medical services, care management services, medical director services and any other direct non-medical type services such as but not limited to personal care etc.

b) Managed Care Revenues – includes capitation, subrogation, COB, and reinsurance recoveries (net of expense)

c) 2006 Risk-Sharing for Dane County Voluntary SSI Managed Care Program – The intent of the risk sharing is to protect voluntary programs, during the initial year of start up, from incurring excessive losses that may be associated with adverse-selection and/or low enrollment that may not cover fixed costs.

II. Introduction: Medicaid Risk-Sharing for the Dane County SSI Voluntary Managed Care Program

The risk-sharing mechanism between Health Plan for Community Living (HPCL) and the Department is a maximum of $300,000 (symmetrical risk sharing of gains or losses) as outlined below. At no time shall the Department's payment for risk sharing under this contract exceed 5.0% of the total annual adjusted Medicaid member premium.

III. Time Period

The time period covered by this Addendum is May 1, 2006, through December 31, 2006, inclusive. The computation of gains/losses, and all sharing in those gains/losses by the Department, will be based on the cost (direct member expenses less an administrative percentage of 15% of Capitation Revenue) incurred by HPCL during the contract period. Only SSI capitation revenues incurred during this contract period will be included in the calculation of gains/losses subject to risk-sharing under the terms of this Addendum. Incurred capitation revenue will included the final CDPS adjustment.

IV. Sharing of Gains/Losses

The Department will share losses with HPCL as long as HPCL will share in gains with The Department. Losses will be shared only after HPCL has expended all SSI managed care revenues, including but not limited to all payments associated with either stop loss or reinsurance for the SSI managed care line of business. Furthermore, after depleting all of its SSI managed care program revenues, HPCL must have expenses in excess of revenue associated with the provision of member services to its enrolled SSI managed care program population, in order to qualify for risk-sharing payments under the terms of this Addendum:

a) **Computation of Gains/Losses:** Only revenues from SSI managed care premiums, and other payments associated with SSI managed care enrollees shall be included in the gain/loss calculations covered by this Addendum.

Only member expenses for the SSI managed care population enrolled in HPCL shall be included in the gain/loss calculations covered by this Addendum. This amount of (aggregate) SSI managed care program gain/loss subject to risk-sharing shall be audited by an independent certified public accounting firm as part of the annual HMO audit in accordance with generally accepted accounting principles.

i. **SSI managed care program revenues:** SSI managed care program revenue will be based on all SSI managed Care program premiums, after any CDPS adjust paid during the term of this contract, as specified in paragraph B.5. under Article XV above.

ii. **SSI managed care program expenses:** Only member service expenses will be considered in computing SSI managed care program gains/losses. These incurred direct member service expenses will be based on generally accepted accounting principles. The total gain/loss will be the total SSI managed care program revenue in i. above less an allowance of 15% administrative expense (15% of total incurred capitation), less SSI managed care program member expenses defined herein. The Department reserves the right to audit the HMOs audited financial statement.

HPCL shall use generally accepted accounting principles (accrual accounting). Final settlement of risk sharing shall always be based on the audited financial statement for that period.

HPCL shall document actual payments to any entity that has any equity ownership, or controlling interest in itself or in a subcontractor that HPCL is doing business with in serving the SSI population. The HMO standard independent audit requires HPCL to demonstrate that any such payments to an affiliate (CLA) are reasonable and within "arms length". HPCL shall provide such documentation to the Department upon request.

HPCL (and its subcontractors) shall follow a prudent buyer approach. The prudent and cost-conscious buyer refuses to pay more than the going price for an item or service. The Department may employ various means for detecting and investigating situations in which cost seem excessive at its own expense.

V. Risk-Sharing

a) Risk-Sharing Guidelines

i. SSI managed care program gain/loss assumed/covered by HPCL under this risk-sharing agreement shall be limited to an amount equal to:

- 100 percent of any member service gain/loss up to $500,000.
- 0 percent of any member service gain/loss between $500,001 - $800,000 (DHFS corridor).
- 100 percent of any remaining gain/loss.

ii. No more than 180 days after the end of the contract period the HMO shall submit to the Department the following calculation related to persons who were SSI managed care enrollees during the contract period.

Loss Example

1.	Total SSI Incurred Capitation	=	$6,359,883
2.	Less 15% of Capitation related to administrative expense	=	$953,982
3.	Total Member Service Capitation	=	$5,405,900
4.	Member Services (net of COB, reinsurance, Subrogation etc.)	=	$6,224,021
5.	Total Loss subject to risk sharing	=	$818,121
6.	100 percent HPCL Covered Loss up to $500,000	=	$500,000
7.	The next $300,000 Covered by Dept	=	$300,000
8.	Remainder of Loss Covered by HPCL	=	$18,121

Gain Example

1.	Total SSI Incurred Capitation	=	$6,359,883
2.	Less 15% of Capitation related to administrative expense	=	$953,982
3.	Total Member Service Capitation	=	$5,405,900
4.	Member Services (net of COB, reinsurance, Subrogation etc.)	=	$4,580,900
5.	Total Gain subject to risk sharing	=	$825,000
6.	100 percent HPCL assumed Gain up to $500,000	=	$500,000
7.	The next $300,000 Gain assumed by Dept	=	$300,000
8.	Remainder of Gain assumed by HPCL	=	$25,000

Reporting Requirements

HPCL will submit the audited calculation of risk sharing no later than June 1, 2007. This provision also requires HPCL to provide all data requested by the Department that is directly related to establishing HPCL's SSI managed care program costs, including all data necessary to establish the direct member service costs associated with HPCLs SSI managed care population.

Risk-Sharing Payments

Payments for risk-sharing will take place no later than ninety (90) days after Department receipt of HPCL's audit report.

In WITNESS WHEREOF, the State of Wisconsin has executed this agreement:

Managed Care Organization	**State of Wisconsin**
Official Signature	Official Signature
Printed Name	Printed Name
Title	Title
Date	Date